HOSPITAL ABSTRACTS

A MONTHLY SURVEY OF WORLD LITERATURE

PREPARED BY THE DEPARTMENT OF HEALTH

AND SOCIAL SECURITY

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HOSPITAL ABSTRACTS

Vol. 18 April, 1978 No. 4

HOSPITALS IN GREAT BRITAIN

474. KERNICK, D. P. and DAVIES, S. **Problems in the development of the community hospital concept.** *British Medical Journal*, London, 1977, Nov. 5, vol. ii, pp. 1238-1239.

The 1962 hospital plan for England and Wales called for the integration and consolidation of hospital facilities into central district general hospitals and saw no case for retaining small hospitals in any but remote areas. It was soon obvious that this plan was not strictly relevant and that many patients in district general hospitals did not need access to their diagnostic and treatment facilities. As a consequence the concept of the community, or general practice, hospital evolved. The two main problems in the development of this concept are outlined: (i) it is difficult to allocate a definitive role to the community hospital in the context of an overall health care plan because of the difficulties in evaluating alternative courses of treatment; and (ii) the attitude of the general practitioner towards the new concept has not been fully considered. There can be no national policy on community hospitals. Each region must adopt its own approach, within a general framework, taking into consideration local social, geographical and medical factors.

475. **New concept in community hospitals.** *Nursing Mirror*, Sutton, 1977, Oct. 13, vol. 145, no. 15, p. 9.

The Gloucester Centre, a community hospital for the mentally handicapped and the first of its kind in Britain, has been opened at Orton Longueville, Peterborough. The aims of the project were: (i) to integrate the hospital into the local community by building next to a residential area; and (ii) to provide a home-like environment for 100 residents and 30 day-patients. There are five self-contained residential units, four for adults and one for children, and the main block houses the activities centre, dining room, administrative offices and therapy and treatment rooms. When fully operational, the hospital will have a staff of 200, including about 100 nurses.

476. RIDE, T. J. **Developments in the post-war health services 2.** *Nursing Times*, London, 1977, Sept. 22, vol. 73, no. 38, occasional papers, pp. 125-127.

The article outlines the main developments within the health services over the last 30 years, but excluding the re-organization of 1974. In 1968 the Central Health Services Council set up a committee which reported on psychiatric nursing and in 1969 the Hospital Advisory Service was set up to visit, initially, long-stay hospitals and make reports. Circulars and white papers on the care of the mentally ill were issued between 1971 and 1975. The Department of Health and Social Security was established in 1968 and the first Green Paper on the re-organization of the National Health Service was published in the same year. Various bodies continued to examine all aspects of the Service. The complaints procedure, the changing attitudes to abortion, family planning

and drug abuse, and the question of private beds in National Health Service hospitals have been some of the issues resulting in discussion and legislation over the last decade.

HOSPITALS IN OTHER COUNTRIES

477. HALBOUT, H. Problèmes d'actualité en France. **[Current problems in France.]** *Gestions Hospitalières*, Mantes, 1977, Oct., no. 169, pp. 691-692, 694-696.

The author first gives a historical review of the position of the public hospital in French society and then briefly indicates the main problems which affect it to-day. These are: the position and the training of the hospital director; the introduction of multidisciplinary management teams; the vexed question of the charge to patients and how to alter the basis on which it is calculated; the sometimes overhasty introduction of computer programming as a management tool; and inflation. The Government's present objectives are to remedy the inequitable distribution of care facilities, to develop programmes of prevention, and to match the health services to the needs and aspirations of the population.

478. ROCHAIX, M. Rapport relatif au système de santé du Grand Lyon. **[Study concerning the health system of Greater Lyons.]** *Techniques Hospitalières*, Le Kremlin-Bicêtre, 1977, Oct., vol. 33, no. 385, pp. 55-58.

This is a short survey of hospital provision in Lyons, which is higher than the national average (seven beds per 1,000 inhabitants instead of five). There are two large university hospitals (and 600 new doctors every year), and three specialist hospitals—children's, neurology, and cardiology. Plans for future provision are discussed in general terms.

479. FILIPPO, J. W. Een uitdaging aan de gemeenschap vraag en aanbod in de gezondheidszorg. **[A challenge to the community: question and answer on health care (in the Netherlands).]** *Instelling-Management*, Amsterdam, 1977, Oct. 26, vol. 9, no. 10, pp. 19-25.

The paper is the report of a speech by the Director General of the Diaconessen Hospital, Leiden, at the opening of the new premises of Kruisheer & Hallink, architect specialists in hospital design, Rotterdam. He discusses the Government's move towards a reduction in the number of hospital beds (aiming at four per 1,000 population) in relation to economic pressures and extension of social services. Capacity and quality of the health services are determined by supply and demand. Realization of rights to health care and growth of the retired population has led to expansion of the services. Four factors leading to increased costs are discussed: (i) collective financing directed towards individual need; (ii) disregard of costs where supply and demand meet; (iii) lowering of the threshold of tolerance of what constitutes a health problem; and (iv) development of expensive medical techniques. The present attitude of increasing dependence on health services is questioned and a greater financial responsibility from the patient is recommended. Reduction of hospital beds could be achieved by reducing the number of admissions and the average hospital stay. This would require a shift from clinical to polyclinical treatment with expansion of the number of general practitioners, social workers, psychologists, etc. Unfortunately there has not yet been sufficiently firm Government action.

480. **Spotlight on health care in Dubai.** *Middle East Health Supply and Service*, London, 1977, Nov., vol. 1, no. 10, pp. 28-30.

As elsewhere in the United Arab Emirates, health services in Dubai are free. With a population of about 210,000 in an area of only 1,500 square miles, the demand on services is high, particularly with the influx of labour for the many industrial and construction projects. Long-term planning, effectively carried out from an early stage, has ensured that the health services have managed to cope with the needs not only of Dubai, but of neighbouring states as well. The 393-bed Rashid Hospital, with all-specialist in-patient and out-patient facilities, was officially opened on 29 March 1973. Three major extensions are now under construction. The contract has now been signed for the 630-bed Dubai General Hospital, a 14-storey building with a helicopter landing pad. The Al Maktoum Hospital (the original main general hospital in Dubai) is also being extended. Other health service facilities include two central and six peripheral clinics.

481. KNIGHT, L. **Kaiser: a pattern for health care?** *Middle East Health Supply and Service*, London, 1977, Nov., vol. 1, no. 10, pp. 62-64, 66.

The Kaiser Foundation is the world's largest non-governmental health care delivery organization. With a basis in industry it now covers three million people in six regions of the United States. The development of the system is outlined and brief details are given of its regional structure, medical staffing, preventive medicine programme, prepayment scheme, and financing, and of the Kaiser Medical Center, San Francisco.

482. SIMON, J.-M. Le rôle des hôpitaux universitaires dans l'agglomération de Paris et la région Île-de-France. **[The role of teaching hospitals in Paris and in the Île-de-France region.]** *Techniques Hospitalières*, Le Kremlin-Bicêtre, 1977, Oct., vol. 33, no. 385, pp. 51-54.

The author sketches the history of the *Assistance Publique* in Paris and describes the present situation with regard to hospital bed provision. The population of Paris itself is falling while that of the suburbs is rising and more general hospitals are being constructed on the edge of the city. Since the average length of stay in hospital is also falling, fewer beds will be required in Paris. Since the services provided by the university hospitals in the city are of very high quality and attract 17 per cent of their patients from outside the region, the *Assistance Publique* intends to regroup and co-ordinate its highly specialized units and its research and teaching structures around the university hospitals, to expand their out-patient departments, and to add day hospitals and rehabilitation centres to the services which they provide.

(Also in *Revue Hospitalière de France*, Paris, 1977, Nov., vol. 42, no. 305, pp. 849-854.)

PLANNING, DESIGN AND CONSTRUCTION

DETERMINING SIZE OF HOSPITAL AND BED NEEDS

See Abstract Nos. 577, 606

DESIGN OF INDIVIDUAL GENERAL HOSPITALS

483. SIBOLE, W. R. **A community helps shape the future of a hospital.** *Hospital Administration in Canada*, Don Mills, 1977, Oct., vol. 19, no. 10, pp. 4, 33.

A community questionnaire was used in determining a long-term plan for the Cottage Hospital, Uxbridge, a 49-bed hospital outside Toronto. The administration wanted to discover the reason for the decrease in the number of in-patients and also to cater for an expected increase in population in the area. Sixty-six per cent of the respondents lived within four miles of the hospital and virtually all had attended it as in-patients, out-patients or visitors. The survey confirmed the community's support for the hospital and the comments made resulted in up-dated recommendations relating to the role of the hospital and its long-term plan. The master plan for new buildings gave priority to the admitting, casualty and out-patient departments, the laboratories, the kitchen and the radiology department.

484. BONHOMME, C. and ARNAUD, Y. L'hôpital de Mauriac . . . an 1: premier hôpital tout électrique de France. **[The hospital of Mauriac . . . year one: the first all electric hospital in France.]** *Techniques Hospitalières*, Le Kremlin-Bicêtre, 1977, Oct., vol. 33, no. 385, pp. 83-87.

A new 124-bed medical and surgical block was added to the Mauriac Hospital in the Auvergne, 722 metres above sea level, in 1976, and electricity was chosen as the sole form of energy. The capital cost was very high, involving insulation of the ground (three-metre bands of 60 mm. thick polystyrene around the external walls), 60 mm. thick polyurethane in the external walls, and double glazing. The basic level of heating is provided by cables buried in concrete; these come on automatically if the external temperature falls below 10°C; otherwise heating is provided by individual convectors in each room. The running costs for the first year show that the cost of heating one cubic metre is 8.52 francs as compared to the average cost in French hospitals which is 11 to 15 francs. The features of the installation are described in some detail and there are two photographs and a table showing consumption of electricity for each of the first 12 months of operation.

485. Mattenhof—ein neues Krankenheim der Stadt Zürich. **[Mattenhof—a new hospital for the city of Zurich.]** *Veska*, Aarau, 1977, Sept., vol. 41, no. 9, pp. 399-409.

The 204-bed Mattenhof long-stay hospital for the elderly and chronic sick in the Zurich suburb of Schwamendingen, one of several designed to meet the needs of the city, was completed at the end of 1975. The seven ward floors rise above the two-storey podium housing administrative and common services. The first ward floor has 23 beds (three single, six double and two four-bedded rooms for patients needing special psychiatric care: the remaining six floors each have 29 beds (three single, five double and four four-bedded rooms). Each ward, on a single corridor plan, also has an isolation room and all patients' rooms face south. The four-storey residential block has 132 single rooms: half of these have their own baths, toilets and cooking facilities while the remainder (mainly for student nurses and the less permanent staff) have only wash-basins and share other facilities. There is also a day nursery for the young children of staff. The paper includes a site plan, a plan of each floor, and five photographs.

486. Lahti Central Hospital. **[Lahti Central Hospital (Finland).]** *Sairaala*, Helsinki, 1977, nos. 8/9, pp. 307-322.

For general medical care Finland is organized into 21 central hospital Districts. The construction of central hospitals has been carried out by central government with local councils contributing toward the cost. Lahti Central Hospital was begun in 1972 (architects: Ark Kitehititoimisto Helge Railoky). The overall capacity of the building was approximately 237,500 m^3, including 194,400 m^3 of hospital space, 12,100 m^3 of heating centre and 30,000 m^3 of housing. The building costs total approximately 190 million Finnish marks. The aim of the hospital is to provide 546 beds for in-patient, out-patient and prophylactic medical care to the surrounding communes, with a population of approximately 200,000 inhabitants. The hospital was opened in 1976 in a series of phases. Details of the engineering services and organization of departments are given. Lahti is the first central hospital in Finland to place beds for tuberculosis patients in the same premises as other beds.

EXTENSIONS AND RECONSTRUCTIONS

See also Abstract No. 495

487. Hôpital Saint-Louis; programme de reconstruction. **[Saint-Louis Hospital: programme for reconstruction.]** *Hôpital à Paris*, Paris, 1977, Sept./Oct., no. 41, pp. 453-458.

The St. Louis Hospital in Paris has 919 beds at present, of which 34 are for patients who suffer from leprosy. It is intended that the historic parts of the hospital, which date from the 17th century, should be preserved and, apart from the leprosarium, be converted to non-hospital use, and that a new technologically advanced 800-bed acute hospital for adults be built around the site. The reduction in the number of beds implies that the average length of stay will be curtailed and that out-patient facilities will be expanded. The specialties within the new hospital will include the present hospital's world-famous dermatology unit which will have 160 beds, the haematology unit (135 beds), and the plastic surgery unit (70 beds); and new departments for nephro-urology and gastro-enterology will be established.

DESIGN OF SPECIAL HOSPITALS OR UNITS

See Abstract No. 599

ENGINEERING SERVICES

INSTALLATIONS IN GENERAL

488. MINIHAN, E. P. and MYLREA, K. C. **How codes can effect the adoption of technology: a specific example.** *Hospitals*, Chicago, 1977, Sept. 16, vol. 51, no. 18, pp. 141-142, 144, 147, 150.

This paper reports a study undertaken to investigate the effect of the 1971 National

Electric Code (NEC) on the use of isolated electric systems (IESs) in Wisconsin hospitals. The study consists of data obtained from a variety of resources, but principally from hospital staff. The sample of hospitals included were in two categories: completed prior to the 1971 NEC; and built after the 1971 NEC or currently being constructed. In the light of the findings, it can be assumed that the extensive use of IESs in non-explosion hazard areas prior to the 1971 NEC was the result of the recommendation of architects and consultants. This, coupled with a lack of clinical engineering capability on the part of the hospitals, resulted in the blind acceptance of this technology by the hospitals. Hospitals must develop their own body of expertise and their own sources of adequate information in order to be in a better position to assess perceived technological problems and the available solutions, to exert greater control over the types and quality of technology used, and to effectively monitor and influence the content of regulations.

TRANSPORT IN GENERAL

489. GORGASS, B. and FREY, G. Der Rettungshubschrauber im Sekundäreinsatz. **[Rescue helicopters in secondary missions.]** *Fortschritte der Medizin*, München, 1977, Nov. 3, vol. 95, no. 41, pp. 2460-2461, 2464-2465.

During the past five years the Ulm helicopter rescue service has made 560 'primary' operational flights (where doctors have flown to accident or emergency sites) and 1,150 'secondary' flights (for transferring patients from one hospital to another for urgent treatment). This ratio of 560 'primary' to 1,150 'secondary' flights is unusual for Western Germany and reflects the local hospital structure and the population spread. This paper analyses the 1,150 'secondary' flights. Normally helicopters are not used for distances of less than 15 km: 72.4 per cent of flights are of 70 km or less and 12.6 per cent are over 100 km (the longest distance is 170 km to the burns unit at Ludwigshafen). The reasons for inter-hospital transfers by helicopter are grouped under eight heads: the most frequent are head injuries (30 per cent), intensive care and respiratory care (25 per cent) and medical treatment (24 per cent). Since these helicopters can be regarded as mobile intensive care units they need to meet certain requirements as to equipment and space: recommendations are made for the improvement of these helicopters.

EQUIPMENT, FITTINGS, FURNITURE

EQUIPMENT GENERALLY

See Abstract No. 488

MEDICAL EQUIPMENT

See Abstract No. 536

STAFF GENERALLY

STAFF COMPLEMENTS

See also Abstract Nos. 583, 596

490. GUTZWILLER, F. and others. Struktur des Spitalpersonals und durchschnittliche Aufenthaltsdauer von Kranken. **[Structure of hospital staff and patients' average length of stay.]** *Veska*, Aarau, 1977, Sept., vol. 41, no. 9, pp. 431-438.

In a study of the relationship of staff structure to average length of stay in the United States, Sweden, England and Switzerland national figures for these four countries as well as figures for a single district hospital of comparable structure in each country have been compared. Both the national data and those for the individual hospitals show longer average length of stay in Sweden and Switzerland than in the United States and England. The two latter countries use more staff per patient day. The differences are found for all diagnostic groups, and in particular for hernia patients, and they cannot be explained by age and sex differences in the case load. The effect of these differences on the quality of care is not clear although the reason for the variations seems to be the differing health service organization rather than the medical needs of the population. The results of the study are set out in a number of statistical tables and charts.

RECRUITMENT

See Abstract Nos. 500, 593

RELATIONS BETWEEN ADMINISTRATIVE AND MEDICAL STAFF

See Abstract No. 503

CONDITIONS OF SERVICE

See Abstract No. 501

STAFF MANAGEMENT

See also Abstract Nos. 504, 508, 509

491. PARRISH, W. C. **Is fear a part of your management style?** *Health Care Management Review*, Germantown, 1977, vol. 2, no. 3, pp. 17-24.

Management-by-fear is the domination of subordinates through systematic application of formal authority, coercion and oppressive controls and the use of threats and negative motivation to accomplish goals and objectives. Those who manage by fear may seem to accomplish their hospital's goals and objectives, but whatever short-term benefits are obtained, through their systematic negative motivation, they are ultimately harmful to the hospital. Leaders who can express respect for subordinates, show tolerance for honest mistakes made in the pursuit of organizational goals, and place trust and confidence in subordinates are practising supportiveness, the key to successful leadership today. A sense of identity with the job motivates people to give their best. If the job offers a chance for growth, recognition, achievement, promotion and personal satisfaction, then the subordinate will seek self-control and self-responsibility.

STAFF RELATIONS

492. HILL, S. **Healthy first steps towards harmony in the future.** *Health and Social Service Journal*, London, 1977, Sept. 30, vol. 87, no. 4560, pp. 1370-1371.

A scheme of participative management, (that is, the staff taking part in management decisions), was set up at the Northampton General Hospital with the help of outside consultants supported by Regional Health Authority staff. General agreement to such a project by management and staff must be secured and preliminary informal discussions are useful. At Northampton, this agreement was forthcoming. Once problems have been identified by training sessions attended by all grades of staff, appropriate groups can be set up to deal with them. Once a solution is agreed, implementation is a management responsibility. Problems settled at Northampton, with varying degrees of success, included staff location, meal ordering and distribution and car-parking. The experiment has been halted by financial stringencies but the progress made so far promises well for the future.

493. GUIMAÎTRE, B. Les relations du travail dans les hôpitaux publics. **[Working relations in public hospitals.]** *Revue Française des Affaires Sociales*, Paris, 1977, July/Sept., vol. 31, no. 3, pp. 3-41.

In this third and final article on working relations between different groups in the hospital, the author examines the structure and functions of the internal bodies where exchanges of views are possible: the consultative medical committee, the joint technical committee, the hygiene and safety committee, and the committees on which management and staff have equal representation and which deal with conditions of work. She also describes the workings of some national bodies and the hospital trades unions. She believes that in the French public hospital the dissatisfaction felt to-day in particular by the nursing and medical staff has its roots in the traditional and heirarchical nature of the internal structures, which makes communication between the different groups difficult and fails to recognise the importance of communication. Modern medicine demands team work and participation and the author suggests that this cannot be achieved without a re-structuring of the channels of communication.

STAFF TRAINING

See also Abstract Nos. 505, 510-515, 523, 524, 527, 612

494. SUEUR, M. La formation discontinue des cadres infirmiers: cette formule est-elle à développer? **[In-service training for nursing officers: should it be expanded?]** *Gestions Hospitalières*, Mantes, 1977, Oct., no. 169, pp. 711-717.

The staff and students at three centres, where part-time training for managerial nursing staff is provided, were interviewed or completed questionnaires in order that a general view could be obtained as to the advantages and disadvantages of this type of scheme. The programmes of study in these centres extended over 18 months, two years, and 30 months respectively and the students attended for four periods of four to nine weeks, five periods of six weeks, or seven of two to six weeks. The main disadvantages were that the students felt that they were always on the move and that the intervals

between study periods were too short to enable them to achieve anything while at work. The 18-month course was considered to be too short and the 30-month course too long. The programme of studies in each centre is briefly outlined.

STAFF WELFARE

See also Abstract Nos. 519, 625

495. WYATT, J. and GALSKI, T. **The psychological impact of hospital expansion.** *Health Care Management Review*, Germantown, 1977, vol. 2, no. 3, pp. 51-56.

John F. Kennedy Medical Center, Edison, N.J., was opened 10 years ago. In 1972, it began a $14 million construction programme to double the size from 205 to 415 beds, add a 48-bed rehabilitation facility, broaden clinical services and begin the development of a mental health institute. The centre, while still a young facility, experienced sudden, rapid and constant change for a period of three years. This paper examines the psychological effects on the staff of these changes. They included: shock; deterioration in personal relationships, particularly between disciplines; and lowering of morale. Ways in which the anxieties of staff were reduced are discussed. They included: openness between the staff and administration; staff council; a telephone extension on which staff could air grievances and make suggestions; and meetings to discuss plans.

496. Een diepgaand onderzoek: de problemen van medewerkers en bewoners in bejaarden- en verpleegtehuizen. [**A searching study: the problems of staff and patients in old people's and nursing homes.**] *Instelling-Management*, Amsterdam, 1977, Oct. 26, vol. 9, no. 10, pp. 37-41.

The Braunschweig Municipal Social Services carried out a study into conditions in 20 homes. All managements, 147 staff and 1,002 residents were interviewed. Managements varied from trained nursing staff of different grades to managerial specialists, full and part time. Administrative, domestic and catering staff outnumbered nursing staff. Staff were questioned on age, marital status, salaries, training, working hours and conditions. Their observations were noted on settling of patients, conflicts, sexual attitudes, noise, cleanliness, mentally declining patients, work involvement of patients, rules and regulations. The majority of staff were women and some general conclusions were made that nursing and medical training could be improved, that training did not always match the work and that activating treatment is not yet sufficiently practiced. Residents, 83.3 per cent of which were women, were questioned on age, finances, spending, reasons for living in a home, choice of home, personal and communal accommodation, food, papers to read, organized activities, freedom, leisure time, loneliness, etc. Replies are given with figures in percentages. It was generally found that preparation for life in a home had been insufficient, that 50 per cent had made their decision themselves and that the situation and reputation of the home plus the degree of independence had played an important part in their choice. Residents' councils were welcomed, but only 13.3 per cent of the residents wished to be a member.

497. BUTLER, E. A. and HAY, B. J. **The passionate statistician: a computerised record of nursing sickness and absence. 1.** *Nursing Times*, London, 1977, Nov. 24, vol. 73, no. 47, occasional papers, pp. 149-152.

This paper traces the development of a batch computer system that collects and

analyses sickness absence details of all nursing staff to nursing officer level in St. Thomas' Health District, London. A feasibility study was followed by a pilot trial before the system was implemented throughout the district in February 1976. The system, written in COBOL, is run in batch mode on the hospital's Rank-Xerox Sigma 6 computer once a week.

SPECIAL CLASSES OF STAFF

ADMINISTRATIVE AND CLERICAL STAFF

See also Abstract Nos. 503, 504, 539, 545

498. LASSERRE, J. and MAZEREAU, G. 'Les risques du métier . . .' ou la responsabilité personnelle du directeur d'hôpital. **['Risks at work . . .' or the personal responsibility of the hospital director.]** *Gestions Hospitalières*, Mantes, 1977, Oct., no. 169, pp. 683-684, 686-688, 690.

The director of a French psychiatric hospital (who in this case was also a doctor) was recently found guilty of allowing staff to take their meals with the patients and not declare this benefit in their tax returns. The court which tried the case was the Court of Budgetary and Financial Discipline and the authors examine its organization and mode of operation as well as its judgment in this particular case. They question the validity of the court's judgment which hinged on the director's failure to observe a ruling given in a Ministerial letter, and point out that the judgment implies that the director has responsibilities but no power to take decisions on local matters.

MEDICAL STAFF

499. STOUT, R. W. **What is a general physician? His role in the teaching hospital.** *Ulster Medical Journal*, Belfast, 1977, vol. 46, no. 2, pp. 119-122.

Over the last few years the nature of the work of the general physician in the teaching hospital has changed considerably. His exact functions are no longer clear and it is not certain whether he has a future in the large general hospital. The reasons include: the growth of sub-specialties; and the increasing age of the population and the high preponderance of diseases of old age which require hospital treatment for social rather than strictly medical reasons. There are several particularly important functions for the the general physician: (i) he is important in dealing with emergency medical cases; (ii) there remain patients who have multi-system diseases; (iii) medicine is a rapidly developing subject and new topics of importance can arise rapidly; and (iv) the fourth and not least important function of the general physician is his teaching role. Of three possible proposals for the inter-relationship of the three levels of medicine, it is suggested that the best proposal for general medicine would be to merge the second and tertiary strata so that all general physicians will have a special interest and experience, and conversely all sub-specialists will undertake general medicine.

500. HAMM, M. **Taking the guesswork out of physician recruitment.** *Hospitals*, Chicago, 1977, Sept. 16, vol. 51, no. 18, pp. 167-168, 172-173.

The problem of medical manpower in rural areas is outlined and some of the

reasons for shortages of physicians listed. In order to overcome the problem, a variety of recruitment and retention strategies should be considered. They include to: establish an organized and ongoing recruitment process; follow a detailed plan to solve the problem; prepare a package of competitive benefits and incentives; and develop a sound marketing strategy. Some of the pitfalls to be avoided are outlined. The success of several hospitals is mentioned, together with the assistance available from federal authorities and private foundations. The need for a programme to encourage physicians to stay once they have been recruited is stressed.

501. JUNIOR HOSPITAL DOCTORS' ASSOCIATION. **Junior hospital doctors' handbook.** Windsor, Junior Hospital Doctors' Association, 1977, 57pp. £2.00

This is a guide to the terms and conditions of employment of junior doctors under the National Health Service. Areas considered include: the junior doctors' contract; employment law and the hospital doctor; guide to terms and conditions of service; and details of the British Hospital Doctors' Federation. A recommended form of job description is included as an appendix.

502. UHL, H. S. M. **The whys and hows of continuing medical education.** *Trustee*, Chicago, 1977, Sept., vol. 30, no. 9, pp. 47-48, 50.

Continuing medical education is essential if high standards of professional performance are to be achieved and maintained. The trustees can carry out their responsibility for providing continuing medical education by: maintaining a strong communications network; regular reports based on medical audit procedures; encouragement of the use of problem-oriented medical records; arranging a formal plan for educational programmes; and providing the special facilities required (library, conference room and audiovisual equipment). The finance for continuing medical education must be included in the hospital budget; medical staff may be asked to contribute towards its cost.

503. EVANS, R. L. **Why do they act that way? A trustee's guide to physician behavior.** *Trustee*, Chicago, 1977, Sept., vol. 30, no. 9, pp. 30-34.

Three groups are responsible for the hospital's functioning in most American hospitals: the board of trustees, the medical staff, and the administration. They are in constant or at least reasonably frequent communication. This paper first examines briefly intercommunication, role understanding and individual makeup in these three groups. It then goes on to look at and try to understand the physician and some of his behaviour patterns, both as an individual and as part of a group. The complex relationships between the medical staff and the other parts of the triumvirate are understandable if one studies the individual and group characteristics of physicians and understands that they should neither be dictated to nor treated as children.

504. SCHULZ, R. and DETMER, D. **Physician/hospital teams: how to get them going.** *Trustee*, Chicago, 1977, Sept., vol. 30, no. 9, pp. 38-41.

Barriers which keep physicians and hospital management from purposeful team effort and problem solving include: physicians and administrators have different orientations; time constraints; largeness begets looseness; and personal insecurities

clash with institutional goals. The answer to these barriers lies in organizational and interpersonal approaches. Organizational methods of team building include: clarify goals; specify responsibility in formal terms; establish task forces, project groups and co-ordinating committees; lean on liaison staff; appoint representatives in residence; and consider consensus management. Pointers to the improvement of communications include: spring no surprises; encourage closeness; focus on problems not personalities; ignore power and status; make dissension work for you; work towards personal and group goals simultaneously; share information; and show interest in others.

505. SMITH, D. **Training in the NHS—doctors and nurses.** *Health and Social Service Journal*, London, 1977, Oct. 7, vol. 87, no. 4561, pp. F9-F12.

The paper discusses possible general changes in areas of training for both nurses and doctors. A combination of theoretical study and ward work is the best form of nurse training, but is not always easy to achieve. The use of programmed learning and audio-visual aids in the training of both nurses and doctors can help to: (i) relieve the shortage of teaching staff; (ii) allow the student to study at his own pace; and (iii) give staff more time to discuss teaching methods. 'Common Core' elements in curricula for some nursing and related specialties are possibilities for the future. The Joint Board of Clinical Nursing Studies has done valuable work in promoting specialized courses. Ward management, staff appraisal and relationship to the community are all nurse training areas which are currently receiving attention. Present and proposed schemes to help the consultant with management skills are also discussed in this paper, and the importance of the role of the community physician in resource management is stressed.

NURSING STAFF

See also Abstract Nos. 491, 497, 505, 528, 596, 625

506. DAVIES, C. **Continuities in the development of hospital nursing in Britain.** *Journal of Advanced Nursing*, London, Sept., vol. 2, no. 5, pp. 479-493.

This paper gives a broad historical perspective of the development of nursing in this country and pinpoints an underlying strategy which is still relevant today. The subordination of nurse training to the hospital service is the element in this strategy which has met with most resistance. The Nurse Registration Act of 1919 secured a minimum standard of nursing but also limited numbers, while continuing stress on the 'vocational' aspect of nursing delayed action on matters such as salaries and conditions in the 1930's. A re-organization of nursing work was recommended by the Wood Committee in 1948, but even after the Salmon report (1966) and the Briggs report (1972), the traditional strategy with its emphasis on administration and routine can still be seen. Despite the introduction of a wider basis for training, the continuity of these traditions at ward level have tended to preclude discussion about the nature of nursing work and how it might be changed.

507. SCHOL, D. **Nursing in Europe: Luxembourg.** *Nursing Mirror*, Sutton, 1977, Oct. 13, vol. 145, no. 15, pp. 31-33.

This article continues the series investigating nursing education in EEC countries and

deals with nursing education in Luxembourg. Nurse training now follows the European pattern with basic courses lasting three years. The minimum entry age is 17 years and prospective students must hold either a paramedical pre-training certificate or a diploma of intermediate education in biology and social studies. The six schools of nursing use the block system and a minimum of 1,500 hours theoretical instruction is given. In the first year, students are taught basic subjects related to the human being and the hospital environment, the second year is centred on patient care and the pathological process, and in the third year the emphasis is on interpersonal relationships. The course culminates in a state examination which includes both written and practical tests.

508. Ampliacion de las funciones de la enfermeria. **[Expansion of nursing duties.]** *Policlinica*, Barcelona, 1977, Sept./Oct., no. 41, pp. 53-54, 57, 58.

The gradual extension of the nurse's role in Canada, in particular in sparsely populated areas in the North and in rural areas in many Provinces where there are few doctors, is described in some detail. The need for advanced training was recognised as early as 1962 when a course in advanced obstetrics was introduced at Dalhousie. In 1973 a joint Canadian Medical Association-Canadian Nursing Association statement defined the priorities, functions, attributions, education, and work situation of nurses, and officially recognised the extension of their activity. Many Canadian universities now provide higher education for nurses and the hospital schools have broadened their basic training courses and introduced post-basic training. The Canadian Nursing Association is at present examining what means can be used to ensure that training for rural and family or community nurses is of a sufficiently high standard.

509. WARD, A. R. **New method of nursing rostering proves successful in Buller.** *New Zealand Hospital*, Auckland, 1977, May/June, vol. 29, no. 2, pp. 14-15.

A system was established at the Buller Hospital, Westport, New Zealand, which allowed nursing staff to know their days off and shift patterns for up to a year in advance. Certain constraints were identified and listed and surveys were conducted with a variety of possible roster patterns. A seven-day shift system was finally agreed. The cycle allows two weekends off, one Saturday, one Sunday and one batch of split days off every seven weeks. Staff are permitted to change duties by mutual arrangement. The main advantages of the new system are: (i) new staff can be informed of their duties before they begin work; and (ii) the time spent by the day supervisor in drawing up rosters has been greatly reduced.

510. CHAPMAN, C. M. **Image of the nurse.** *International Nursing Review*, Geneva, 1977, Nov./Dec., vol. 24, no. 6, pp. 166-167, 170.

This paper about the image of the nurse was presented to the 1977 International Council of Nurses Congress in Tokyo. Some famous nursing stereotypes are to be seen in Dickens' Sairy Gamp and Florence Nightingale, and the Nightingale image of the young, middle class woman still persists today, despite the fact that 15 per cent of qualified nurses in Britain are men and that 65 per cent are mature married women. Also, graduate nurses are seen as a threat to the knowledge and power of doctors and are generally regarded with suspicion. The stereotype is now very different from the role that the nurse actually undertakes and nurses, themselves, need to ensure that the correct image of nursing is portrayed both by the media and by recruitment literature.

511. HARRISON, J., SAUNDERS, M. E. and SIMS, A. **Integrating theory and practice in modular schemes for basic nurse education.** *Journal of Advanced Nursing*, London, 1977, Sept., vol. 2, no. 5, pp. 503-519.

This report by members of the Research Unit of the General Nursing Council, describes factors influencing the integration of theory and practice in modular schemes of nurse education. Altogether 359 student nurses from different types of hospitals completed a questionnaire after about two years of training. Five of the questions were directly related to integration. The best integrated modules were in the more specialized areas such as paediatrics and obstetrics, while the more general areas of medicine and surgery were less well integrated. The most frequently mentioned reasons for non-integration were: (i) lack of relevance of lectures; (ii) modules covering complex topics; (iii) poor staffing on wards; and (iv) the tendency of teaching staff to stress general rather than specific nursing skills. Responses varied from one type of hospital to another, as did the suggestions for improving modular schemes. Changes of staff make it difficult to give students a consistent amount of trained supervision on the ward, but suggestions are made as to how integration can be achieved despite problems of staff allocation.

512. OWEN, G. M. **Curriculum integration in nursing education: a concept or a way of life? A study of six courses integrating basic nursing education and health visiting in a single course.** *Journal of Advanced Nursing*, London, Sept., vol. 2, no. 5, pp. 443-460.

The aim of the study was: (i) to record the development of the six courses which integrate basic nursing education and health visiting; and (ii) to attempt to identify any differences between health visitors who trained on these courses and those who had taken the three-year SRN course with an extra year for health visiting. The research project consisted of: (i) a survey of the opinion of tutors and students on the combined courses; and (ii) a questionnaire to all students completing the courses in 1972, with a matched control group completing the one-year health visiting course at the same time. There were significant differences in job expectation between the two groups, but only one difference in the expectation of nursing and health visiting in general. The group on the integrated course showed a more clearly differentiated view of the nurse and the health visitor. Overall, the students were quick learners and were highly orientated towards the patient. A questionnaire for employers revealed that the majority of respondents rated young health visitors trained on the integrated course higher than average.

513. WRIGHT, M. S., GILMORE, M. and TIERNEY, A. **The nurse/graduate in nursing: preliminary findings of a follow-up study of former students of the University of Edinburgh degree/nursing programme.** *Health Bulletin*, Edinburgh, 1977, Nov., vol. 35, no. 6, pp. 317-323.

A longitudinal study, introduced in 1969, to verify the career patterns of graduate nurses is described. A postal questionnaire was sent to all members (21) of five intakes between 1960 and 1975 at Edinburgh University. An analysis of the interim findings (to July 1976) indicated that 75 per cent of the graduates were still nursing and that the majority were in patient care posts. Only a small number were involved in teaching or research—or employed as nurse administrators. The most common reasons for leaving

nursing were marriage and family commitments, however most of these graduates felt that they would return to nursing as soon as possible.

514. OHLSON, V. M. **Baccalaureate nursing education in the United States.** *International Nursing Review*, Geneva, 1977, Nov./Dec., vol. 24, no. 6, pp. 168-170.

This description of United States degree nursing courses was presented to the 1977 International Council of Nurses in Tokyo. The first degree course was started in New York in 1899, but the two decades 1950-1970 saw degree courses fully established in the United States. Graduate nursing courses are one of the most popular career choices and the majority of potential students come from a middle class background, directly from high school or after some years at College. Increasing emphasis is being placed on sociological, cultural, psychological and biological aspects of nursing in these courses. Since 1973 there have been more graduate nurses than those qualifying from schools of nursing.

515. ALASZEWSKI, A. M. **Suggestions for the reorganization of nurse training and improvement of patient care in a hospital for the mentally handicapped.** *Journal of Advanced Nursing*, London, Sept., vol. 2, no. 5, pp. 461-477.

In nurse training, the requirements of the health service overrule the educational needs of nurses. This project concentrated on the allocation of student nurses to wards in a hospital for the mentally handicapped and the author maintains that present regulations are not suited to this type of hospital. Student nurses are moved from one ward to another every eight to 12 weeks, resulting in instability for the patients, a lack of ward teams and the existence of rigid rules. Nursing experience is often interpreted as knowing how to classify patients rather than how to establish relationships with them as individuals. The author suggests that the hospital under study should be divided into three units: (i) non-ambulant; (ii) adult; and (iii) children, with each of the four wards of the unit having a stable nursing team liaising with appropriate community services. A cross-section of wards from each unit would form a sector, and a student nurse would work on one sector only, allowing for a longer placement in each ward.

516. NORTHERN IRELAND. DEPARTMENT OF HEALTH AND SOCIAL SERVICES. NURSING SERVICE STUDY GROUP. **Report on the feasibility of achieving economies and increased efficiency in the hospital and community nursing service.** (Chairman: D. McCullough). [Belfast], Department of Health and Social Services, 1977, [65]pp.

The terms of reference of the Nursing Service Study Group were to examine the feasibility of achieving economies and increased efficiency in the nursing sector in Northern Ireland. This report focuses attention upon those areas where the nursing content and influence is greatest and where there would be scope for improving the economy and effectiveness of the nursing service. The areas evaluated in the hospital are: (i) the ward; (ii) the ward sister; (iii) the ward team; (iv) the nursing officer; (v) senior nursing management; and (vi) effective use of nursing staff. The community nursing services in Northern Ireland are assessed and recommendations outlined. Eight appendices are included.

517. SCHMIED, E. **Allocation of resources: preparation of the nursing department budget.** *Journal of Nursing Administration*, Wakefield, Ma., 1977, Sept., vol. 7, no. 7, pp. 31-36.

The ability to make use of the process of budgeting and resource allocation is essential to nurse managers. This process includes the management of three major areas: supplies, capital and salaries. This paper defines the budget and outlines a method of preparing budgets for these three areas, and then relates the process to the whole hospital budgeting system.

518. JONES, C. **The nursing process—individualised care.** *Nursing Mirror*, Sutton, 1977, Oct. 13, vol. 145, no. 15, pp. 13-14.

This paper was first read in May 1977 at the Wessex Regional Conference of the Royal College of Nursing Association of Nursing Education. It outlines the phases involved in the problem-solving approach to nursing care known as the nursing process. Phase one deals with the assessment of the patient and is used to develop a case history and to collect information concerning the patient's condition. Phase two is concerned with planning the patient's care in view of the assessment of his needs. The third phase is to implement the care plan. Finally phase four evaluates the care given. The author emphasises that these phases may overlap or occur simultaneously depending upon the needs of the individual patient.

519. GUSTAFSSON, R. Å. Sjukhusets psykosociala arbetsmiljö: rutinmässiga tekniska moment hotar trivsel och vårdsamspel. **[The psycho-social working environment of the hospital: routine technical factors threaten happiness and harmony in nursing care.]** *Landstingens Tidskrift*, Stockholm, 1977, Sept., vol. 64, no. 10, pp. 33-34.

The author is one of a research team of four investigating the psychosocial working environment in the hospital as part of a large project (the social psychology of labour) at Stockholm University. The tasks of the hospital are organized more or less at random round the central concept of acute care—at the expense of the working environment in departments serving other needs, e.g. long-term care. Staff working in long-term care units assess their expectations and performance against the yard-stick implanted in them during training (acute care is all), and feel their work is pointless because their patients have no prospect of rehabilitation. Training is based on instilling an ability to operate a range of technological apparatus, mostly required in acute care, although a more broadly based syllabus, and the opportunity to apply it in practice, would tend to make staff much happier at their work. Increased flexibility is a desirable aim. Increased specialization has led to a form of alienation from the broader aims of the health service—staff often regard themselves as mere cogs in a machine or as workers on a mass-production line. The fully-automated organization has become the main driving force in the system, directing and controlling human beings instead of being controlled by them. Seventy-six per cent of contacts between staff and patients last less than 30 seconds, and are of a routine (technical) nature. Hospital care must be re-humanized, as it was in the old charity hospitals. Any factor or system which prevents ward staff engaging themselves in depth with their patients must be removed.

520. WENDT, R. Specialiseringen inom sjukvården minskar värdet i arbetet. **[Specialization in hospital care reduces the value of hospital work.]** *Vårdfacket*, Stockholm, 1977, Oct. 6, vol. 1, no. 18, pp. 4-11.

The article is based on the second report, 'View of a medium sized hospital' (Aspekter på ett medelstort sjukhus), from the 'Psycho-social working environment within the hospital' research group project. The report is based on six or seven-hour interviews with medical and surgical staff in a county hospital, made with the aim of identifying fields for further research (see Abstract No. 519). The first report concluded that long-term care units were always organized as if they were acute wards. The 'acute care model' on which the hospital system is constructed—a healthy person temporarily becomes ill, is diagnosed, cured and discharged—acts perfectly on surgical wards. Those who experience this model are convinced that the system works. Staff satisfaction is high, despite the pressure of work. The identical model, applied, as always, in medical wards, acts dysfunctionally, because the pathological picture is much more diffuse and the patient material older, more anxious, more introspective and more suspicious. Staff job satisfaction is lower. A high degree of specialization, imported from industry is gradually destroying the overall view and making personal contact with patients more difficult. Many staff find that huge aggressions build up while they are at work, which they have to ventilate when they get home: (i) because there is no forum for discussion in the hospital; (ii) because staff traditionally do not conflict with one another; (iii) because it is not done to show one's feelings; and (iv) because of the shortage of time. Hospital work is most difficult for women with children at home. Split shifts, weekend work and unexpected (compulsory) overtime produce a vicious circle of high absenteeism and high turn-over.

521. WHITE, R. **Accountability—a necessity for survival?** *Nursing Mirror*, Sutton, 1977, Nov. 17, vol. 145, No. 20, pp. 25-27; Nov. 24, vol. 145, no. 21, pp. 30-31.

Accountability is distinguished from responsibility. There are three key areas in which nurses have accountability: (i) a professional accountability to their patients or clients; (ii) a managerial accountability to their organization; and (iii) an intra-professional accountability to their peers and to their profession. Each of these areas is discussed and relevant literature cited. It is concluded that the nursing profession has condoned a tendency to demand a professional status without accepting the concomitant onus of professional accountability. Acceptance of accountability must infer some sort of professional audit or peer review. The profession must once again insist on members fulfilling their professional responsibilities and on their being accountable for their professional activities.

522. WISEMAN, J. **A nursing audit of basic care—Further developments and a critical evaluation.** *Nursing Times*, London, 1977, Nov. 3, vol. 73, no. 44, occasional papers, pp. 141-143.

This article is the final part of a paper describing nursing audit. It is a follow-up to two previous occasional papers describing nursing audit procedures in the Blackpool Health District and updates the progress described previously (see Hospital Abstracts Vol. 17, no. 502). Some future developments are indicated and the results of the audit evaluation are reported. The evaluation shows that audit can lead to improved staff

relationships and that audit combined with staff appraisal can lead to an improvement in nursing care. This confirms the hypothesis put forward at the start of the study.

523. PRZEPIORKA, K. M. and BENDER, L. S. **Psychiatric nursing consultation in a university medical center.** *Hospital and Community Psychiatry*, Washington, 1977, Oct., vol. 28, no. 10, pp. 755-758.

Nurses in the medical-surgical children's and maternity departments at the University of Michigan Medical Center, felt that the consultation service provided by psychiatric residents assigned to the department of psychiatry's liaison service did not have specific application to nursing care. In response to their requests, a programme of psychiatric nursing consultation was established. The programme is operated by two part-time co-ordinators who train and supervise the nurse consultants through monthly group sessions and individual supervision. The aim is to set up ongoing consultative meetings with nursing staffs who request help rather than providing only one-time or crisis consultation. During the programme's first year, 146 consultations were given, and an average of 9.5 units received consultation services each month.

524. HEALES, K. **Community psychiatric experience in Ipswich.** *Nursing Times*, London, 1977, Nov. 10, vol. 73, no. 45, Community Outlook, pp. 102, 105-106.

A modular type of training for student nurses was introduced in the psychiatric division of the Ipswich Health District in September 1973. The scheme includes a five-week introductory block followed by 11 modules of experience, each preceded and followed by a week in the nurse education centre. The community module for student nurses lasts 12 weeks. It is proposed to start a six-week community experience module for pupil nurses in January 1979. The community options now available to student nurses are: (i) attachment to a borstal colony for six or 12 weeks; (ii) placement with the community nursing division in Ipswich for two weeks; (iii) Belstead Special School (mental handicap) for six weeks; (iv) attachment to the day hospital, Minsmere Acute Unit, for four or six weeks; (v) attachment to the rehabilitation hospital, St. Audrey's Hospital, for eight weeks; (vi) placement with the psychiatric community nursing service operating from St. Clement's Hospital, Ipswich; (vii) attachment to an adult training centre in Ipswich; (viii) Ashley Downs School for the educationally subnormal; (ix) Seven Rivers Cheshire Home; (x) two-week basic course in social services offered by the Suffolk Social Services Student Training Unit; (xi) two-week field placement with social services; (xii) 12-week residential attachment to the Greenwood's Therapeutic Community; (xiii) two-week attachment to the Organizer of Community Services for Suffolk; and (xiv) a 5,000-word project on a subject with a definite community bias. The construction of the community module programme is outlined.

525. SKEET, M. **Nursing aides, auxiliaries and assistants.** *Nursing Times*, London, 1977, Nov. 17, vol. 73, no. 46, occasional papers, pp. 145-148.

This discussion of the nurse specialist is based on a project sponsored by the Leverhulme Trust. The extended role of the nurse is examined together with some of the administrative and legal implications for health care. Also the function of the nurse specialist in developing countries, in particular Indonesia and the Caribbean, is outlined.

526. LETH-SØRENSEN, S. and ZEBITZ, U. Undersøgelse af sygeplejeelevers sociale baggrund: sygeplejerskefagets rekruttering synes väsentligt forandret. **[Enquiry into the social background of student nurses—recruitment to the nursing profession seems to have changed considerably.]** *Sygeplejersken*, København, 1977, Sept. 21, no. 37, pp. 12-15.

An analysis has been carried out by sociologists of the social, educational and recreational data of 100 student nurses at one Copenhagen hospital (Bispebjerg). There is a clear trend towards student nurses being older and better educated at the commencement of training than they were in 1960, and more men train to be nurses nowadays. These conclusions correspond with those of a much wider investigation conducted by the Board of Health in 1976. Seventy-five of the 100 nurses had been to grammar school, compared with an average of 49 per cent between 1956 and 1975. Although no upper class students were represented, there is an increase in middle class representation and a corresponding drop in working class recruitment. Thirty-two of the student nurses had commenced other (longer) courses of training before starting at nursing school. The younger the student the greater the tendency to drop out of the course. Thirty-nine of the students are married, 10 with children: the same fraction as in the population under 25 as a whole. The older and married students in particular (28 of the 39) stated that the fact that they received pay during training was a significant factor in their choice of career. Free-time activities: sport (53%), politics (10%), theatre (60%), evening classes (17%), correspond to those of the 20 to 29 years age group in Denmark. As far as future plans are concerned, a quarter were undecided, 30 hoped to go abroad, 30 wanted to go into hospital nursing and 16 wanted to work in other institutions or in the primary health service. The article is illustrated with four statistical tables.

527. PALSBO, S. Sygeplejeelever uddannet to måneder i den primäre sundedstjeneste: vi lärte at pleje patienterne på deres egne vilkår. **[Trainee nurses spend two months in primary health service: we learned to care for patients in their own surroundings.]** *Sygeplejersken*, København, 1977, July 20, no. 28, pp. 4-6.

The school of nursing at Aarhus County Hospital carried out an experiment in the autumn of 1976 involving four student nurses working for two consecutive months in the primary health service. The special project was conducted in association with the district nurses and health visitors from two local area offices, an industrial nurse, the ambulance service, and local Health Service institutions. The district nurses were doubtful about the value of this form of training, since patients did not always like 'strange' faces coming into their homes. A preparatory two-week period was therefore spent teaching the students to keep and pass on records, to operate the card index system, to assess care given, and familiarize themselves with the district. During their later, three-week period each was responsible for the care of a small group of patients in a different district, and planning their nursing in co-operation with doctors, the hospitals, home helps, day centres etc. The nurses also spent short periods at an ambulance station, on a psychiatric nurse's rounds, at local schools' screening programme days, and at a food packing factory. At the factory they came up against the workers' generally negative attitude to factory nurses, whom they considered to be of little use. The article is illustrated with a photograph of the four nurses with their tutor, and a detailed timetable of their course.

ORGANIZATION AND ADMINISTRATION

See also Abstract Nos. 477, 495, 520, 628, 629

528. AKIWUMI, A. **Administrative controls in hospital nursing service.** *International Nursing Review*, Geneva, 1977, Nov./Dec., vol. 24, no. 6, pp. 176-181.

The hospital as an organization has some inherent characteristics that make administration very difficult: (i) the humanitarian purpose of the hospital can make strict adherence to policies, regulations and budgeting difficult; (ii) the urgency of care can make resource control ineffective; and (iii) the conflicting interests of many professional groups within one organization. The professional standards and ethics of certain groups can create situations where patient care is secondary to the needs of that group. The systems approach to hospital administration appears to offer an alternative method of intra-organizational communication that does not undermine the role of each professional group. The systems theory as it relates to nurse administrators is described and the author concludes that this approach allows for greater understanding between the groups that comprise the patient care team.

GOVERNING BODIES, COMMITTEES

See Abstract Nos. 498, 503

HOSPITAL ARCHIVES

529. JONES, B. P. **Locating and preserving Oxfordshire hospital records.** *Medical Record and Health Care Information Journal*, Truro, 1977, Nov., vol. 18, no. 4, pp. 328-329.

Three exercises have been carried out since 1969 to locate and catalogue records of the three oldest hospitals in Oxfordshire: Radcliffe Infirmary, Warneford Hospital and Littlemore Hospital. This paper describes the current project, to be completed within one academic year, to locate, list and advise on the care and safe-keeping of any archival material earlier than 1948 which is currently retained in 30 hospitals and units in the Oxfordshire area. The description covers: the extent and condition of the records; the remedial work being carried out; and other classes of document encountered. The procedure followed is outlined. The project, taken as a whole, has been rewarding and worthwhile and it would certainly reduce further losses of hospital records if similar operations could be launched by other area health authorities whose hospital records are not already under specific care and custody.

ECONOMICS OF HOSPITAL MANAGEMENT

See also Abstract Nos. 516, 589, 590, 605

530. RO, K.-K. **Anatomy of hospital cost inflation.** *Hospital and Health Services Administration*, Chicago, 1977, vol. 22, no. 3, pp. 75-88.

The rising costs of hospital service are of public concern because the hospital industry is not subject to the rigorous processes of competition, yet its product is

considered to be one of the necessities of life. This paper examines: the theoretical framework of investigation of cost inflation; the basic statistics of the process of hospital cost inflation; and recent developments in demand and supply factors. The non-profit nature of most hospitals and cost-based reimbursement protect hospitals from the market system of rewards and admonitions where efficiency is a prerequisite for survival. Public policy which could alter the trend of hospital cost inflation is not likely to be adopted. On the demand side, there is a growing consensus for access to care regardless of financial status. On the supply side, the not-for-profit nature of hospitals and mode of third-party payment are not about to change. Within these two basic constraints, however, concrete measures can and should be taken to establish built-in mechanisms which would provide incentives for consumers and promote efficiency.

531. HANAU, C. Rassegna di studi sull'economia ospedaliera. **[Review of studies on hospital economics.]** *Problemi della Sicurezza Sociale*, Roma, 1977, Jan./Feb., vol. 32, no. 1, pp. 27-46.

The author reviews recent studies on hospital economics and in particular studies published in Italy on input/output assessment, the volume of hospital activity in relation to supply of beds and demand for treatment, costs and productivity, economies of scale, and factors which affect hospital efficiency and efficacy. He proposes a model for the development of economic indicators based on a classification of hospitals by type of patient treated, length of stay, and break-down of costs. He points out the limitations of this type of approach, based on one sector (the hospital) only, because of the interdependence of the hospital system with the whole social and health system, and recommends the use of multidisciplinary studies. There are 34 references.

532. THUESON, J. **Hospitals' programs and progress in cost-containment reported.** *Hospitals*, Chicago, 1977, Sept. 16, vol. 51, no. 18, pp. 131-132, 134, 136, 138.

In May 1977 the President of the American Hospital Association asked the chief executive officers of member institutions to submit information on 1976-77 cost containment projects and resulting savings. This paper presents some of the highlights gleaned from the replies that have already been received. They are grouped under the headings: management effectiveness; labour costs; sharing, purchasing; insurance; energy savings; miscellaneous; and patient costs.

533. SWEARINGEN, L. L. **Staff's all-out, ongoing efforts help hospital fight inflation.** *Hospitals*, Chicago, 1977, Sept. 16, vol. 51, no. 18, pp. 125-126, 128.

In 1974 the 300-bed Blessing Hospital, Quincy, Ill., formed a managers' cost containment committee. Cost containment approaches used early in the committee's programme included: letters from the administrator to all staff emphasizing the need for controlling costs; a regular feature in the monthly staff newsletter; showing a film on energy conservation; an honours roll of staff submitting ideas which saved money; a cost containment display case, in which each department in turn had to provide an exhibit; staff encouraged to take time off without pay when their work is finished; and a large chart to record each department's savings. After two years a review of the programme resulted in the following new approaches: bimonthly cost containment newsletter;

suggestions scheme with prizes; discussion of cost containment in orientation programmes which all staff must attend once a year; employees who submit ideas become members of a cost-cutting team; all department heads are encouraged to share cost data with their staff; more department heads are participating in the cost containment committee; and employment of an in-house construction staff instead of employing outside contractors. From 1975 to May 1977, the programme saved about $321,000.

RUNNING COSTS

See Abstract Nos. 532, 533

BED OCCUPANCY, ECONOMIC USE OF BEDS

See also Abstract Nos. 490, 577, 600, 623

534. CHEVALLIER, J. and BELLEVILLE-SEJOURNE, A.-M. de. L'activité d'un hôpital. **[Hospital activities.]** *Hôpital à Paris*, Paris, 1977, Sept./Oct., no. 41, pp. 435-441.

The authors briefly describe their method of analysing the activity at the Jean-Vernier Hospital during its first 14 months of operation, and they present their results in five tables and four figures. In all, 18,508 patients were seen, of whom 44 per cent were admitted at least once. Eighty per cent of the in-patients were admitted directly and only 20 per cent after first visiting an out-patient clinic. On average each patient visiting the out-patient department was seen twice. Twenty-two per cent of the patients seen and 19 per cent of those admitted were children aged less than 14 years.

OFFICE MANAGEMENT AND METHODS

See Abstract No. 541

ELECTRONIC DATA PROCESSING

See also Abstract Nos. 497, 542, 552, 584, 602, 618

535. SAHIN, K. E. **Keeping up with . . . networking in computers.** *Health Care Management Review*, Germantown, 1977, vol. 2, no. 3, pp. 25-29.

The future of health care management may depend on the strength of the marriage of computers and communications. This paper reviews the field of rapidly proliferating networks and their potential impact on health care. A computer network dedicated to health care may in the short-term serve our needs well. But the long-term effectiveness of health care management can best be assured by co-ordinating the rapidly proliferating networks and by paving the way for each network-to-network communication.

536. HOYTE, P. J. **ECG analysis by computer.** *Update*, London, 1977, Oct. 1, vol. 15, no. 7, pp. 579-580, 582, 584, 586, 588, 590.

In 1975 an experimental project was set up jointly by the Department of Health and Social Security and the North Western Regional Health Authority to evaluate the Marquette Muse electrocardiogram interpretation computer system. It was brought

into use at Wythenshawe Hospital, Manchester, which has 1,000 beds, some of them in a large cardiothoracic unit. The objects of the trial have been to assess usefulness, acceptability and potential in different environments, using work study procedures and cardiologist over-reading as necessary. Later the system was extended to two other large hospitals, a small hospital and a health centre. A computer system assistant, based at Wythenshawe Hospital, has responsibility for day-to-day running and organization, liaison, and training of operators. The paper describes briefly the system, the recording 'costs', computer programme and costs. Further details are given of the use of the system by the general practitioners at the health centre.

537. FERNANDEZ PEREZ DE TALENS, A. and PISANI, P. **A data-base system as a decision-taking aid in a cardiologic environment.** *Medical Informatics*, London, 1977, Sept., vol. 2, no. 3, pp. 203-216.

This paper describes a software package for the establishment and management of records of a definite population for clinical use. The records accept both numeric data and free text. The package runs on a minicomputer to allow access to the data base by small clinical groups. In addition to read/write facilities, the system is oriented towards the extraction of user suggested and defined subsets of the population and their analysis. The data structure has been defined so as to: (i) discharge the data entry operator from non-relevant procedures and to maximize his performance; (ii) leave the data base manager free to modify easily the previously defined data base and to upgrade with new, not previously accepted, variables; and (iii) accept data from direct recordings from the patient via automatic instrumentation. The system has been applied to a few different populations with related cardiovascular problems.

MEDICAL RECORDS

See also Abstract No. 632

538. GOGUEL, A. Les archives médicales centrales: analyse des difficultés de fonctionnement. **[Medical records: analysis of difficulties in running the service.]** *Hôpital à Paris*, Paris, 1977, Sept./Oct., no. 41, pp. 445-450.

Medical records at the Ambroise-Paré hospital have been centralized since the hospital opened in 1969. Two problems have existed from the start: patients were given a new number each time they were admitted, and there was not enough storage space. Moreover the records of in- and out-patients are stored separately and, although most records are not bulky, some are, and 2.5 per cent of all records take up one-fifth of the available space. The hospital has 20,000 new admissions and 105,000 out-patient consultations each year. The position is now so bad that it is virtually impossible to locate some records. For the future the author suggests that: (i) a single number should be allocated to each patient; (ii) each addition to a patient's record should be date-stamped; (iii) only essential material should be kept for 20 years (the legal minimum requirement); (iv) documents should be microcopied; (v) some old records should be stored elsewhere; (vi) the contents of the records should be checked by medical staff; and (vii) the coding of diagnostic data for epidemiological purposes, which was abandoned early on for lack of time, should be re-introduced.

539. BURG, G. and RAY, J.-P. Le dossier médical hospitalier: une opinion d'administrateurs. **[Hospital medical records: as seen by hospital administrators.]** *Techniques Hospitalières*, Le Kremlin-Bicêtre, 1977, Oct., vol. 33, no. 385, pp. 62-65.

Since the medical record belongs to the hospital (see Abstract No. 540) the hospital has a duty to preserve it. In French law the president of the hospital medical committee and the director are jointly responsible for the records department. The patient now has the right to be given copies of his X-ray plates, and his general practitioner the right to an account of the diagnosis and treatment of his patient. The author suggests that the patient should have greater access to his record and proposes the introduction of a patient's health book (*carnet de santé*) which would provide a summary of relevant data.

540. JULLIEN, G. and OLLIER, A. Le dossier médical hospitalier: une opinion de médecins. **[Hospital medical records: as seen by doctors.]** *Techniques Hospitalières*, Le Kremlin-Bicêtre, 1977, Oct., vol. 33, no. 385, pp. 59-62.

This is an analysis of the medico-legal aspects of the patient's medical record in French public hospitals. The record is the property of the hospital and the medical head of the unit is its custodian. The authors discuss how much or how little information may be communicated to other doctors, to the patient himself, and to third parties. They emphasise the need to ensure that no breach of professional confidence occurs.

541. BANISTER, R. **Records management systems.** *Hospital Equipment and Supplies*, London, 1977, July, vol. 23, no. 7, p. 22.

Records are the nervous system of an organization upon which it depends for transmission of information and understanding and control of situations. The first part of this paper examines the functions of records and discusses record production, centralized or decentralized filing, temporary or permanent retention, storage of old files, and storage life and weeding. The second part outlines the systems required to meet these functions, covering layout, document flow, transport and handling, work positions, filing methods and costs. The final part examines briefly some modern methods, including carousels, rotary medical filing units, roll-aside stack filing, automated filing and microfilming.

542. WITTE, L. M. and GOLDMAN, J. B. **Minicomputer controls medical record maneuvers.** *Hospitals*, Chicago, 1977, Sept. 16, vol. 51, no. 18, pp. 119-120, 122.

One of the recommendations of a medical record consulting firm following a study at the 300-bed Mount Auburn Hospital, Cambridge, Mass., was that a computerized, central filing system should be adopted. The hospital decided to adopt a dedicated minicomputer system rather than use an outside service bureau. The emergency, outpatient/admitting, radiology and medical record departments all have a cathode ray tube video display unit with an entry keyboard. Each unit is interfaced with the minicomputer, which is programmed with the master patient index. The system and the procedures followed are described. The system is very special because: (i) it is one of the first minicomputer systems dedicated to the management of medical records; (ii) it is a low cost system and will reduce operating costs after amortization of equipment; (iii) it is controlled by the user, the medical record department; (iv) it operates

24 hours a day, seven days a week, without highly trained computer staff; (v) it links medical record use to patient identification; (vi) it permits instant tracking of medical records; and (vii) it creates a data base that can be expanded to include all hospital applications.

PUBLIC RELATIONS

543. JOODE, D. de. Nog weinig praktijk in ziekenhuizen: public relations, een fascinerend terrein met onbegrensde mogelijkheden. **[Public relations, a fascinating service with unlimited possibilities, still too little used by hospitals.]** *Instelling-Management*, Amsterdam, 1977, Oct. 26, vol. 9, no. 10, pp. 43, 45-46.

The author, head of the Information Service of the Free University Teaching Hospital, Amsterdam, describes his public relations as a systematic promotion of mutual understanding between the hospital and various public groups, both internally (departments, services, etc.) and externally (other hospitals, press, authorities, practitioners, transport services, neighbouring residents, etc.). He describes the improvements in internal communications in his own hospital through weekly news bulletins, information booklets for patients and their relatives, booklets for children, internal radio, a patients' journal, complaint channels, explanation of treatment to patients, regular meetings of various sections of staff, a staff council, a monthly staff newspaper, introduction days followed by instruction for new staff members, and a hospital management training course. An opinion poll about the hospital is planned to be conducted among visitors, general practitioners, patients and ex-patients.

LEGAL ASPECTS OF HOSPITAL ADMINISTRATION

See also Abstract No. 549

544. VEATCH, R. M. **What is the scope of hospital ethics committees?** *Hospital Medical Staff*, Chicago, 1977, Sept., vol. 6, no. 9, pp. 24-30.

Before the decision of the New Jersey Supreme Court in the Quinlan case, there had been a few attempts to establish committees at the local hospital level to make, review or advise in decisions regarding the care of the terminally ill. The court's opinion has given a major impetus to this trend and it is an appropriate moment to ask a number of questions. Four general types of hospital committees can be identified: (i) committees to review ethical and other values in individual patient care decisions; (ii) committees to make larger ethical and policy decisions; (iii) counselling committees to provide counsel and support to patients and physicians; and (iv) prognosis committees, which are used whenever there is a difficult technical decision or the physician's judgement merits review. Some of the issues involved are discussed, citing examples of guidelines issued or committees established.

545. WIELK, C. A. **Human experimentation: issues before the hospital administrator.** *Hospital and Health Services Administration*, Chicago, 1977, vol. 22, no. 3, pp. 4-25.

At present, the hospital administrator is seldom involved when the question of human experimentation is raised. But the time has come when he must become aware

of and actively participate in these discussions, as the issue will have a direct impact on the operation of the hospital. This paper reviews the discussion which has evolved thus far to determine the most productive manner in which the hospital administrator can become involved in this vital area. The administrator's interest is threefold: (i) the hospital must adhere to the legal standards established either by law or regulatory control; (ii) the administrator has or should have a vital interest in the medical practice in the hospital; and (iii) the administrator has a moral responsibility to ensure that patients are not subjected to obscure or esoteric projects that do not take the necessary precautions to safeguard human life. The administrator's role is outlined and advice is given on the establishment and procedure of a human research review committee.

FINANCE AND ACCOUNTING

FINANCE

See also Abstract Nos. 517, 615, 619

546. MILLIKEN, J. A. and HADLEY, C. **Cost analysis shows fee schedules are deficient.** *Hospital Administration in Canada*, Don Mills, 1977, Oct., vol. 19, no. 10, pp. 35-40.

To evaluate the efficiency of a proposed Regional Cardiographic Processing Centre, the operational costs of the electrocardiography departments of the two major hospitals in the Kingston area of Ontario, were investigated. The article describes the results from one of them, the Hôtel Dieu Hospital. The following procedures were carried out: (i) a time and motion study of the ECG technicians; (ii) measurement of supplies and materials used; (iii) calculation of space and area costs; and (iv) consideration of the depreciation costs of equipment. The fee for interpretation of an ECG represents another factor in the total cost of the department. The study showed that labour accounted for 60 per cent of the technical costs; depreciation costs were high and the fee for interpretation was lower than the current approved rate. The total operating cost per in-patient ECG was far in excess of the officially calculated cost. There is, therefore, no adequate yardstick of actual cost, and further comparisons need to be made to assess the advantages of a regional processing centre.

547. BERMAN, R. A. **National health insurance: reintroduction of federal controls.** *Hospital and Health Services Administration*, Chicago, 1977, vol. 22, no. 3, pp. 45-57.

With finite resources available for health, all Americans cannot have the highest quality and broadest range of services now accessible to only a few. Therefore, the fundamental issue is decide between a national health insurance programme that assures: (i) that all Americans have equal access to a limited set of services, allowing ability to pay to determine who gets additional services, additional quality, improved accessibility and a broader range of services; or (ii) that all Americans have equal access to the available health services regardless of their ability to pay. The author strongly believes that national health insurance should be based on the latter alternative. He examines some of the options available for achieving this and outlines the essential objectives of a national health insurance programme. Among the recommendations

made are: (i) significant restructuring of the currently accepted third party fee schedules; (ii) development of a national hospital reimbursement schedule based on a fixed rate per stay for appropriate diagnostic categories; (iii) mandatory acceptance of government determined reimbursement fees; (iv) establishment of a National Health Financing Commission and local planning authorities; (v) incentives to encourage the consumer to make appropriate use of the system; and (vi) scaled out-of-pocket limitations for lower income groups.

548. FRIEDMAN, E. **Medicaid: a crop of nettles. (Third of a series).** *Hospitals*, Chicago, 1977, Sept. 16, vol. 51, no. 18, pp. 73-80.

The states and territories that decided to join the Medicaid programme (all except Arizona now) found themselves trying to implement a law that was both vague and complicated. Their attempts have resulted in many different types of procedures, agencies and plans and many different attitudes. This paper presents data that have been accumulated by the American Hospital Association at the time it was written from states selected as representatives of different trends. The statements, attitudes and policies of a few state Medicaid officials are also included. The states covered are New York, Rhode Island, Massachusetts, Maine, Michigan, Mississippi, Arizona and California.

549. WELCH, B. B. **Self-insurance: an area approach to solving the malpractice problem.** *Hospitals*, Chicago, 1977, Sept. 16, vol. 51, no. 18, pp. 81-83.

The North Broward (Fla.) Hospital District operates three major hospitals with a total capacity of approximately 1,200 beds serving a population of about 600,000. When the asking premium for public liability and malpractice cover rose by 575 per cent in less than 20 months, the board of commissioners accepted its lawyers' recommendation that it should set up its own insurance programme. The programme includes a detailed system of evaluating and reviewing each occurrence involving a patient, visitor or physician from which injury or some problem might arise. In describing the new malpractice cover as a 'non-insurance programme', the hospital tries to emphasize to lawyers, patients, the general public and juries (to the extent permissible) that any settlements, judgements or other payments will be taken from limited tax funds. A special reserve account of one million dollars has been set aside, and will probably be increased to two million dollars as quickly as possible. In the first full year of the programme the total cost was $61,000, a saving of more than $2.4 million on the insurance company's premium and less than the interest on the reserve. In December 1975 the board established a scheme for physicians, who pay premiums ranging from $1,283 to $7,979. If claims experience continues to be as reasonable for the next few years as in the first year, the premiums could be reduced if the trustees elect to do so.

SUPPLIES AND STORES

PURCHASING

See Abstract No. 488

ECONOMIC USE OF SUPPLIES, DISPOSABLES

550. MAGGI, R. and SCARPINI, F. Il monouso: 2a parte. **[Disposables: part 2.]** *Technica Ospedaliera*, Roma, 1977, July/Aug., vol. 7, nos. 7/8, p. 46.

This is the second in a series of articles in which the value of using disposable materials in the hospital is examined. Here the authors stress the risk of infection to laboratory staff from broken glass bottles or test-tubes containing infected matter. They point out that the British Public Health Laboratory Service recommends the use of disposable test-tubes, Petri dishes, syringes, and needles. The worldwide incidence of viral hepatitis is reviewed and it is suggested that the risks of contracting this infection could be reduced if disposable dialysis equipment, test-tubes, and gloves were used. The article contains four photographs of disposable equipment, a bibliography containing 32 references, and two tables.

CATERING, DIETETICS, KITCHENS

HOSPITAL CATERING

551. UNKLESBAY, N. F. and DAVID, B. D. **Organizational decisions for food procurement in hospitals.** *Journal of the American Dietetic Association*, Chicago, 1977, Aug., vol. 71, no. 2, pp. 129-135.

Twenty criteria for food procurement in hospitals were drawn up by the Department of Food Science, University of Wisconsin-Madison. A survey was carried out in 204 hospitals in the North Central region of the United States to determine the extent to which the criteria were being applied. Teachers of food purchasing were also sent a questionnaire. Trends and differences in the responses from the hospitals and the teachers were revealing. Scores from hospitals were highest where the hospital had an organized policy for food purchasing. Greater co-operation between teachers and food purchasing administrators is needed to lessen the gap between theory and practice. Detailed results of the survey are shown in three tables.

552. BERGAILA, J. S. and POPE, J. E. **Computerized menu printing system reduces clerical tasks.** *Hospitals*, Chicago, 1977, Sept. 16, vol. 51, no. 18, pp. 185-186, 188.

St. Luke's Episcopal Hospital, Texas Children's Hospital and Texas Heart Institute form a 1,000-bed complex located in the Texas Medical Center, Houston. An expansion programme, which began in 1969, doubled its bed capacity. This paper concerns the solution to one problem that grew worse as the bed complement increased—a cumbersome and time-consuming diet order and menu printing system. After considering several alternatives, it was decided to adopt a computerized system, which has three permanent data files: menu item, diet, and patient. Each day, the computer uses the information on the files to print out individual patient menus, a dietary checklist for individual nursing units, and a listing of patients' names and room numbers for those patients who have received a menu. Although the hospital is not using its own computers, the system has realized annual savings of about $15,000 through the reduction of clerical work and elimination of three posts. It has also enabled the hospitals to offer a more attractive and personalized menu to patients, while increasing departmental efficiency and flexibility.

553. BLERSCHENK, H. Gezonde voeding in bejaardentehuizen de tevredenheid gaat door de maag. **[Wholesome food in old people's homes: the way to contentment is through the stomach.]** *Instelling-Management*, Amsterdam, 1977, Oct. 26, vol. 9, no. 10, pp. 27-28.

The paper is the report of a speech made at 'Anuga' food fair in Cologne. The provision of elderly people with a healthy diet often conflicts with what they fancy. In composing diets account has to be taken of difficulties with teeth, reduced gastric juices and decreasing general health, as well as individual eating habits and wishes. The elderly need much protein, raw or boiled carrots, half a litre of milk, fresh vegetables and lots of vitamins and minerals, preferably served in frequent small meals daily. In Senioren Wohnheim, Brühl, residents are given a choice from two menus from which they can select their own meals. Nutritional values and calories per portion are stated on the menu cards. In 1970 a psychological approach was introduced whereby residents were given a choice in the composition of the menus. This provided a sense of personal involvement and residents became more conscious of health aspects and practical problems of buying, prices, quality and composition. A hostess is always present at mealtimes to attend to immediate criticisms and in addition complaints can be registered through a complaints book. With few exceptions the system has pleased the 600 residents, 50 patients and 180 staff.

554. DOWLING, M. **The case for blast chilling.** *Hospital Equipment and Supplies*, London, 1977, Nov., vol. 23, no. 11, pp. 48-49.

Alternatives to conventional catering operations have failed to make a dramatic penetration into hospital catering. Possible reasons include: the tendency to keep to the familiar way of doing things; the financial control and food quality benefits have not been proved conclusively; and the fairly limited menu and stable population is not considered to call for dramatic change so that a simple compromise is considered preferable. It is in the last area that the principle of chilling food for limited onward storage has gained favour and is being implemented throughout the world. Technical conversion is virtually non-existent. Cooling is carried out in the normal accepted manner. The food is laid out in multi-portion pans, disposable or re-usable, then transported to a blast chilling cabinet for fast chilling in three-quarters to one hour, according to product. The food is then stored at 34°F for up to three or four days. The re-heating time is 12 to 20 minutes.

HOSPITAL DOMESTIC MANAGEMENT

DOMESTIC WORK

555. CHRISTENSEN, T. Rengøring for milliarder. **[Cleaning for a billion kr. (A Danish hospital round-table discussion.)]** *Tidskrift for danske Sygehuse*, Glostrup, 1977, Aug., vol. 53, no. 7, pp. 121-129.

Hospital administration officers are amateurs in the field of the economic and hygienic aspects of hospital cleaning compared with the contract cleaning firms. Politicians decide between tenders on pure financial grounds rather than on the basis

of bacteriological results. The concept of "cleaning" varies from hospital to hospital (old or new; few wash-basins or many), assistant matron to assistant matron (differing routines) and consultant to consultant (punctuality on ward rounds). In a hospital with a cleaning bill of up to d.kr.500,000 a year the cleaning can be done just as effectively by an inside team directed by a highly paid professional leader as by an outside firm—provided it applies the firm's expertise. A high degree of training and planning is required, however, if the hospital's own cleaning services, which usually cost five per cent of the running budget, are not to prove up to three times as expensive as a contractor's. Contractors can offer specialization in management, trained staff, and technical know-how. But a professional cleaning analysis can reveal scope for economies: Norwegian hospitals cost far less to clean per m^2 than Finnish ones, because less demanding cleaning is required—although the bacteriological results are the same. It is not unknown for a hospital to get round compulsory staffing ceilings by contracting more and more work out to cleaning firms, freeing nurses and laboratory staff within the hospital but increasing the cost per m^2 of cleaning to politically unacceptable levels. The criteria for efficient cleaning are: planning, training, high standards, good leadership, and pride in the job.

556. LARSEN, C. Rengøring: kontraktrengøring. **[Cleaning: contract cleaning.]** *Tidskrift for danske Sygehuse*, Glostrup, 1977, Aug., vol. 53, no. 7, pp. 130-132.

Cleaning costs the Danish economy some 5,000 million kroner a year, and cleaning in private homes another 2,000 million. Hospital cleaning costs represent about five per cent of their annual budget, or d.kr. 250 million on a national basis. Professional cleaning directors are currently employed by only 10 hospitals. While there were only 50 cleaning firms in the country as a whole 10 years ago, there are now over 300 in Copenhagen alone; a minority of these firms are organized into one or two large (competing) employers' groups. Other branches involved in cleaning are the cleaning materials producers, and consultant firms. The trade is not very capital-intensive, each job requiring an average investment of d.kr. 1,000 compared with e.g. 50,000 kr. in the metal industries. A government enquiry into cleaning firm trade practices and profits revealed no significant differences in the methods, standards and hours of work in the private and public employment sector, and resulted in an increase in wages for cleaners in public employment. Satisfactory cleaning is based on: (i) a survey of the area involved; (ii) a description of the environment; (iii) an analysis of the factors affecting the environment; and (iv) a definition of the standards demanded. Efficient results are achieved by professional planning, a high level of training, and continual research and development.

557. STRANDBERG, H. Organiseringen av städfunktionen på sjukhus. Erfarenhet och synpunkter. **[Experience of and views on cleaning services organization in the hospital.]** *Tidskrift for danske Sygehuse*, Glostrup, 1977, Aug., vol. 53, no. 7, pp. 133-136.

The introduction of the five-day week in Finland in 1968 meant the establishment of large numbers of new jobs in the health sector; wages and the associated social services comprise 70 to 80 per cent of the cost of running the hospitals. Hospitals therefore rationalized by contracting for specialized services such as cleaning. The advantage of employing an outside firm with trained staff and management is that

one purchases a fully developed, top quality service which free competition forces to keep up with developments in its field in a way no local authority service ever could. The hospital lays down the exact level of cleaning services it wishes to purchase and is not paying for wasted time. It is 10 to 15 per cent cheaper to employ long-term-trained service facilities than it is to work up such services oneself. Hidden economies (reduced maintenance and repairs) can increase savings by another five per cent. A negative factor is that trade union policies are opposed to the introduction of private firms into public institutions. This problem has been solved in Finland by ensuring identical collective agreements for both categories of employees. Where the contracting firm employs nursing staff to train and direct their cleaners, the cleaners are rapidly assimilated into the hospital environment. Time-honoured cleaning routines deserve to be re-examined and revised, in the same way as the internal transport of patients, the serving of food, sterilization services and so on.

558. DANIELSEN, K. B. Hvordan skal renholdet planlegges? **[How should cleaning be planned?]** *Sykehuset*, Oslo, 1977, vol. 40, no. 5, pp. 265-269.

The Norwegian Institute of Industrial Hygiene has proved that the significance to health of floor cleaning is nil; airborne contamination does not originate from the floors but from the circulating air. Floors are generally washed with a mop dipped in an unnecessarily heavy bucket of filthy water and stored overnight, wet, in a noisome cupboard. Nurses and auxiliaries are taught cleaning methods current 20, 30 or 100 years ago. The modern method of cleaning floors is with a mop (dry, damp or impregnated), provided the floor has a homogenous, non-porous surface. Mops may be disposable (dry, impregnated or damp) or washable (to be used impregnated or damp). Damp mops must be washed at at least 80°C for at least 10 minutes, spin-dried, and stored under refrigeration. The weekly wet wash is carried out by spreading clean water on the floor with spreader mops and drying it off with clean drying-mops. Cleaning costs vary from n.kr. 70 to 170 per m^2 per annum, all according to how well the hospital is planned. Cleaning functions must be taken into account in planning new buildings; the economies attained may be as much as 100 kr. per m^2 a year, or a million kroner a year for a whole hospital. Good cleaning is a matter of planning, training and organization; cleaning is a form of maintenance, and is the proper responsibility of a trained cleaning manager on the technical staff of the hospital.

559. RUSTEN, G. Hvordan funksjonerer rengjøringssystemet i praksis? **[How does the cleaning system function in practice?]** *Sykehuset*, Oslo, 1977, vol. 40, no. 5, pp. 258-264.

Lillehammer County Hospital applies an American cleaning system under which a cleaning manager is responsible for a staff of assistant managers who direct the individual specialist teams in charge of daily cleaning, window-cleaning, systematic ("spring") cleaning, and floors. Cleaning tasks are programmed on the basis of time and motion studies. The methods involved are: (i) cleaning of rooms and fixtures; (ii) wet or damp mopping; (iii) carpet cleaning; (iv) "policing" the floors (i.e. picking up rubbish etc.); and (v) a weekly cleaning of the corridors and halls with battery-driven machinery. Carpeted floors are maintained by shampooing and steam-cleaning; hard flooring is wax-polished. The cleaning depot comprises an infected items reception area; a washroom with a washing machine, tumbler drier, and disinfectant facility; and a clean area for storing clean equipment and loading trolleys. The cleaning

routine is described in detail, as are routines for the daily cleaning of bathrooms and sanitary installations, and patients' ward rooms, isolation wards and sluices. The continual "spring cleaning" of individual areas, getting round the entire hospital about twice a year, and the dispatch to the laundry by the wards (nurses) of infected bedding and curtains, are also noted.

HYGIENE IN THE HOSPITAL

HOSPITAL INFECTIONS

See also Abstract Nos. 563, 564

560. WEINSTEIN, R. A. and STAMM, W. E. **Pseudoepidemics in hospital.** *Lancet*, London, 1977, Oct. 22, vol. ii, pp. 862-864.

In the period 1956 to 1975 the Center for Disease Control of the United States Public Health Service investigated 181 epidemics in hospitals. After careful case definition and appropriate testing, 20 (11 per cent) of the outbreaks were found to be false. Pseudoepidemics appeared in apparent spatial and temporal clusters of presumed infections located most commonly in the blood and the respiratory tract. Investigations revealed errors in specimen processing (55 per cent cases), including contamination during collection or transport, cross-contamination in the laboratory, and incorrect identification of organisms. Thirty per cent of the pseudoepidemics represented community-acquired diseases and errors in clinical diagnosis accounted for the remaining 15 per cent. The prevention and detection of pseudoepidemics depends on : (i) quality control of laboratory routines and specimen processing; (ii) continuing education of laboratory staff; and (iii) close co-operation between laboratory workers and clinicians.

SOURCES OF INFECTION

561. CASEWELL, M. and PHILLIPS, I. **Hands as route of transmission for Klebsiella species.** *British Medical Journal*, London, 1977, Nov. 19, vol. ii, pp. 1315-1317.

Seventeen per cent of the 28 staff of an intensive care unit were found to have Klebsiella species contaminating their hands, and on four occasions the sterotypes were identical with those colonising or infecting patients on the day of sampling. Klebsiella had been transmitted to nurses' hands following various nursing and ward procedures, some surviving for as long as 150 minutes. Handwashing with chlorhexidene hand cleanser reliably gave 98 to 100 per cent reduction on hand counts and the introduction of such handwashing by staff before moving from one patient to another produced a sustained reduction in the number of patients affected by Klebsiella species. Staff clothing, air and dust-borne particles rarely contained Klebsiella.

PREVENTION AND CONTROL

See also Abstract Nos. 560, 561

562. ABRAMS, J., FLORMAN, A. L. and HOLZMAN, R. S. **Infection surveillance team prepares for move to new facility.** *Hospitals*, Chicago, 1977, Sept. 16, vol. 51, no. 18, pp. 177-178, 180.

Two years before Bellevue Hospital Center, New York, moved into a new single high-rise facility, the hospital's administration asked the members of the infection control committee to review the new building and its plans, and to make recommendations that would ensure that appropriate measures would be taken to minimize the dangers of hospital-acquired infections. This paper is an account of how that committee met its charge. The multidisciplinary committee meets monthly, but its working arm, the surveillance team, meets weekly. In the spring of 1973, the surveillance team made a preliminary survey of the new building and identified important differences between the new and old facilities, primarily in the air-conditioning, plumbing, transport and waste disposal systems. Further investigations of these are outlined. Other studies were made of the catering department, operating suites, and cleaning plans.

563. BOTOLFSEN, A. Nosokomiale luftveisinfeksjoner. Forebyggende tiltak. **[Preventive measures against nosocomial respiratory infections.]** *Sykehuset*, Oslo, 1977, vol. 40, no. 6, pp. 327-329.

Most hospital respiratory infections are due to Gram-negative bacillae, particularly Gram-negative pneumonobacillae. The most useful preventive measure against respiratory hydrostasis is physiotherapy, if necessary associated with suction. The frequency of occurrence of respiratory infection is highest in intensive care units, i.e. following anaesthesia or respirator treatment. Contaminated air is usually to blame; this can be eliminated by maintaining the water in the humidifier at the pasteurization temperature of 60°C. The hose (airline) must be long enough to bring the temperature of the inspired air down to 35°C. Failing a temperature of 60°C, a cold humidifier can be filled with a 0.1 per cent aqueous solution of chlorhexidine. All respirator equipment must be carefully decontaminated and sterilized by heat or 30 minutes' immersion in e.g. two per cent glutaraldehyde. Respirator patients should be in isolation, and staff must adhere strictly to sterile procedures. Good hand hygiene plays a vital part in the prevention of nosocomial infection—including respiratory infection.

564. BOOK, L. S. and others. **Clustering of necrotizing enterocolitis.** *New England Journal of Medicine*, Boston, 1977, Nov. 3, vol. 297, no. 18, pp. 984-986.

Between August 1972 and February 1977 there were 74 cases of necrotizing enterocolitis in the Intermountain Newborn Intensive Care Center. This paper presents a clinical description of the cases and the epidemiological investigations carried out. Despite the failure to recover a common pathogen, the epidemiological evidence suggested that a transmissible agent was involved. Control measures designed to interrupt faecal-oral spread of that unknown agent were implemented. When a definite case was identified an isolation system was implemented consisting of a separate room, use of gown and gloves, strict handwashing, separate staff for infants with the disease, and separate diaper and laundry pails. When a "suspect' case was identified the same system without the separate room was adopted. These measures were associated with a statistically significant reduction in the incidence of the disease.

565. Die Bedeutung einer Bettenzentrale. **[The importance of a bed centre.]** *Veska*, Aarau, 1977, Sept., vol. 41, no. 9, pp. 423-425.

For functional and economic reasons it is desirable that the disinfection of beds should be undertaken centrally. The bed centre is best sited on a subground floor and storage space for 12 to 15 beds is all that is necessary. It is important that there should be a clean and a dirty side. The various techniques for disinfecting bedsteads and bedding are briefly described and assessed. Ultraviolet radiation is particularly effective for surface disinfection while thermal steam disinfection is most frequently used for mattresses. The paper includes a diagram showing work flow in a bed centre and a plan of a disinfecting chamber for surface disinfection with alcohol.

STERILIZATION

See Abstract No. 567

AIR HYGIENE

566. WHITE, P. A. F. **Clean air in hospitals.** *Hospital Engineering*, London, 1977, Aug., vol. 31, no. 6, pp. 16-20.

An attempt is made to define clean air. There are few places which carry as many hazards associated with the cleanliness of air as hospitals. Parts of the hospital where the cleanliness of air needs special consideration are: laboratories, operating theatres, special care wards, isolation rooms, ultra special care units and general wards. Consideration is given to the engineering and technology that are involved in providing clean air environments in them: high efficiency filters, laminar floor, air flow control and fume cupboards. Finally the special requirements of operating suites and ways of dealing with them are discussed.

567. DUNKELBERG, H. and HARTMETZ, G. Zur Belastung der Raumluft durch Äthylenoxid im Bereich klinischer Sterilisationsanlagen. **[Recording the air pollution by ethylene oxide in the region of clinical sterilization installations.]** *Zentralblatt für Bakteriologie, Parasitenkunde, Infectionskrankheiten und Hygiene*, Stuttgart, 1977, May, vol. 164, no. 3, pp. 271-278.

In the course of several studies eight sterilization installations in different hospitals were visited and 126 samples of air taken. The method of determining ethylene-oxide concentrations in air is discussed. High concentrations in air are mainly due to the ethylene oxide emission by the sterilized items. Contamination was also registered in surrounding areas due to incorrect emission of the ethylene oxide into the open air. The experiments indicate that some ethylene oxide sterilizers used in hospitals may lead to pollution of the air. There should be regular checks on ethylene oxide concentrations in the air within the surrounding areas of clinical sterilization installations.

SAFETY MEASURES

CIVIL DEFENCE IN THE HOSPITAL

568. MUMENTHALER, H. Der Sanitätsdienst des Zivilschutzes und seine Zusammenarbeit mit den Spitalern. **[The civil defence health service and its co-operation with the hospitals.]** *Veska*, Aarau, 1977, Sept., vol. 41, no. 9, pp. 395-398.

Civil defence medical services as planned in Switzerland fall into four groups: (a) protected operating centres, in the basements of existing hospitals, normally with 248 beds, operating theatres, and diagnostic and treatment rooms; (b) emergency hospitals, also with 248 beds; (c) medical aid centres, with 128 beds, facilities for ambulant treatment and an operating theatre; and (d) medical posts, for medical practices and with 32 beds and a simple treatment room. For the whole of Switzerland 200 type (a) or (b) are planned (one per 30,000 population); 400 type (c), one per 15,000 to 20,000 population; and 1,500 type (d), one per 4,000 to 5,000 population. At present 40 per cent of (a) or (b), 55 per cent of (c) and 35 per cent of (d) have been completed. The protected operating centres (a) are administered by the hospital concerned; all other units come under the civil defence organization. Co-operation between all the types of civil defence medical units, both as regards staffing and the care of patients, will be an essential feature and this is discussed in some detail.

RADIATION HAZARDS

569. PARISOT, H. Radioaktive Abfälle, ihre Entstehung und Beseitigung im Bereiche der Medizin. **[Radioactive waste, its origin and removal in the field of medicine.]** *Mitteilungen der Österreichischen Sanitätsverwaltung*, Vienna, 1977, Oct., vol. 78, no. 10, pp. 267-269.

Radioactive waste from telecurie and brachycurie treatment is in the kilocurie or 100 millicurie range with a half life of about five years. These preparations, and in particular cobalt 60, are regarded as no longer usable after a few years and are stored as waste. These wastes are not bulky but are highly active and need to be fully screened at all stages. Waste from nuclear medicine and other applications are bulky but with a half life of less than 14 days can be treated as inactive waste after 24 half life periods. Iodine 125, with a half life of 60 days, needs special storage. The problem of a 12-month storage of short-lived nuclides, as well as that of the long-lived, is lessened by the collection service of the Austrian Centre for Radioactive Waste.

THE PATIENT

ADMISSION AND RECEPTION

See Abstract No. 575

WELFARE OF THE PATIENT

See also Abstract Nos. 496, 582, 604, 608, 617, 633

570. DEL NISTA, L. La charte du malade hospitalisé. **[The patient's charter.]** *Techniques Hospitalières*, Le Kremlin-Bicêtre, 1977, Oct., vol. 33, no. 385, pp. 76-82.

This is a systematic examination of the hospital patient's rights as specified in the 1974 Decree: the right to admission and discharge, and the right to information, communication, and human dignity. The author describes the procedures for normal admission and discharge, including discharge against medical advice. The patient has the right to be received on admission by staff specially trained for this purpose and to be given a brochure containing all the information concerning hospital routine, etc. which he may require during his stay. Although the doctor is obliged to communicate to the patient information concerning his medical condition, this obligation is waived in the case of a serious or fatal prognosis. The right to dignity covers the right to privacy and integrity: the latter is shown to be nil for patients suffering from tuberculosis, alchoholism, drug addiction, or venereal disease.

571. ALBIMUS, I. and others. Vi må have fälles grundholdning til patienterne. **[We must have a common basic attitude towards patients.]** *Sygeplejersken*, København, 1977, Sept. 28, no. 38, pp. 4-6, 16.

Two doctors and three senior nurses on the staff of Finsen's Institute (for the treatment of cancer and similar diseases) were asked what medical and nursing staff do to ensure uniformity of information and attitude to patients. The assistant matron discusses the nurse's conflict of loyalty in response to queries from an anxious patient—is it to the patient, who wants and fears the truth, or to the doctor, who is trying to conceal it. It is easier to inform patients for whom treatment is successful than those for whom there is no hope. One is much less emotionally involved with a patient who does not understand his situation than with one who has been told the truth, but it is far more satisfactory to work *with* patients than in a conspiracy against them. Nursing training does not prepare nurses for the aggressiveness shown by patients who have been told about their situation and have thought about nothing else for days or weeks. The family must also be involved in discussions and in assisting the patient. In direct answer to the questions put, the surgical department has held staff meetings involving all 60 to 70 members, in order to agree on the best means of informing patients. The medical department has held similar meetings, plus courses in which patients have also taken part, in order to understand the background to the patient's needs. The assistant matron sums up by saying that one will never achieve full uniformity in relationships with and information for patients, but a common basic attitude can only do good.

572. VOLICER, B. J., ISENBERG, M. A. and BURNS, M. W. **Medical-surgical differences in hospital stress factors.** *Journal of Human Stress*, Framingham, Mass., 1977, June, vol. 3, no. 2, pp. 3-13.

Psychosocial stress due to hospital stay can be measured using the Hospital Stress Rating Scale. Nine levels of stress can be analysed with this scale and each patient is asked to identify, from a list of 49 situations often experienced by patients in hospital,

those situations which he/she has personally experienced. The controlled variables are: age; education; number of stays in hospital; number of years since previous stay; and seriousness of illness. Medical patients had the highest ratings for stress due to financial problems and lack of information. The use of these findings to reduce stress among hospital patients is discussed.

VOLUNTARY SERVICE, VOLUNTARY WORKERS

573. SIEPKER, B. B. and others. **The volunteer program in the psychiatric division of a children's hospital.** *Hospital and Community Psychiatry*, Washington, 1977, Sept., vol. 28, no. 9, pp. 697-699.

The Children's Memorial Hospital in Chicago has a volunteer training scheme headed by a paid director of volunteer services. The child psychiatry department uses most volunteers, whose ages range from 16 to 63. In a typical month an average of 90 volunteers gave about 1,900 hours service in the out-patient department, the day hospital and the 18-bed in-patient unit. Volunteers are interviewed with care and once assigned to a suitable task, start on a course of on-the-job training. Most act as group workers, different types of therapists and remedial tutors, but some are trained for more specialized work. A questionnaire given to volunteers in 1974 revealed that they understood and enjoyed their work and many wanted to receive further training. The main reasons for the success of the scheme are: (i) the hospital staff's acceptance of the volunteers as part of the health care team; and (ii) the co-operation between the staff and the volunteer department.

HOSPITAL SOCIAL WORK

574. SMITH, L. L. and MCNAMARA, J. J. **Social work services for radiation therapy patients and their families.** *Hospital and Community Psychiatry*, Washington, 1977, Oct., vol. 28, no. 10, pp. 752-754.

The University of Utah Medical Center, Division of radiation therapy, treats over 700 patients a year, most of them as out-patients. Since August 1974 a full-time social worker has worked with the cancer patients and their families. He makes personal contact with the patient and family on their first visit to the radiation division, answers questions, provides information on community services, and generally lets the patients and family know that they can call on him at any time during their treatment. He also follows up patients who are still seriously ill after treatment, and tries to maintain regular contact with the families of patients who have died.

TRANSPORT OF PATIENTS

575. JOHNSON, J. **When a node is as good as a link in improving access.** *Health and Social Service Journal*, London, 1977, Sept. 30, vol. 87, no. 4560, pp. 1374-1375.

The planning of health services does not incorporate any procedure for ensuring that services are provided at sites most accessible to the public. The aims of the survey described were: (i) to determine the 'natural' catchment areas of the district general hospitals in the North Western Region; and (ii) to identify areas with poor

access to such hospitals. The transport terminal and the location of the hospitals on a map were represented by 'nodes' and joined by 'links'. This system was translated into a computer programme to estimate travelling times taken by patients to reach their nearest district general hospital. The calculation of the shortest time from any defined point to a district general hospital makes the catchment area easy to define. An estimation of the population residing within these boundaries shows up the 'deprived' areas, where public transport needs to be improved or, in a longer term, new hospital facilities provided.

HOSPITAL CARE

See also Abstract Nos. 515, 516, 518-522, 590, 591, 613, 614, 620, 624, 630

576. TILQUIN, C. **The schizophrenia of patient classification.** *Dimensions in Health Service*, Toronto, 1977, Sept., vol. 54, no. 9, pp. 26-28.

The variety of patient classification schemes prevents classification being used as a tool in regional and national planning of nursing resources. A codified classification must exist to ensure the distribution of available resources according to the needs of each hospital unit at each nursing shift. Naturally, a degree of professional judgement can be exercised within the codified scheme at unit level. The design of a classified scheme should include the following two stages: (i) formulation of criteria to determine the class to which the patient belongs; and (ii) an estimation of the care needs of the patients in each class, in minutes and for all categories of staff. Classification codes are sometimes questioned by nurses, and, where possible, a code should be drawn up according to an objective set of criteria and directed towards care required rather than care rendered.

577. DONALDSON, S. N., WHEELER, M. R. and BARR, A. **Demand for patient care.** *British Medical Journal*, London, 1977, Sept. 24, vol. 2, pp. 799-802.

A study was carried out by the Northern Health and Social Services Board and the Department of Health and Social Security in Northern Ireland to determine the extent to which patients were receiving appropriate levels of care. Criteria were established for assessing the level of care required by each patient in hospital, residential home or in the community. A sixth of the in-patients did not require hospital services, while five per cent of those not in hospital did need hospital services. Those who were justifiably in hospital and those who should have been totalled 1,193, which represents a rate of four per 1,000 for all types of hospital except regional specialties, mental subnormality, psychiatry, obstetrics and paediatrics. The significant finding was that the current provision of two to 2.5 acute beds per 1,000 is higher than the demand which is actually 1.5 per 1,000. A further two to 2.5 beds per 1,000 would be needed in supporting hospitals providing nursing care.

578. MCCLEARY, D. **Joint Commission on Accreditation of Hospitals—twenty-five years of promoting improved health care services.** *American Journal of Hospital Pharmacy*, Washington, 1977, Sept., vol. 34, no. 9, pp. 951-954.

A brief history of the Joint Commission on Accreditation of Hospital (JCAH), as

well as its structure, purpose and activities is presented. The procedure for developing JCAH standards for health care facilities is discussed. Also presented are the survey and accreditation processes. It is concluded that as long as the United States values its tradition of voluntarism and believes in positive motivation, the JCAH will be an effective influence on improved health care services.

579. GRIMES, D. S. **Quality assurance, British style.** *Hospital Medical Staff*, Chicago, 1977, Sept., vol. 6, no. 9, pp. 11-17.

In contrast to the United States, quality control in the clinical specialties in Great Britain is barely recognized and there is no significant pressure for its introduction. It does not, however, appear to have led to a decline in the quality of medical care as might have been expected. Formal machinery deals with specialized areas and intrudes little if at all upon the day-to-day work of most physicians. The informal machinery is of greater importance but, being subtle and quiet, is hardly noticed. Formal scrutiny includes monitoring of the prescribing habits of individual general practitioners, the confidential enquiry into maternal deaths, the Hospital [now Health] Advisory Service, and minor moves toward formal peer group control. British physicians have maintained a great amount of professional independence and are not in competition with one another. If they tend to overtreat, it is because they fear loss of professional credibility rather than loss of income. Many regard the review of clinical practice as a threat to clinical freedom. It is generally considered that the best way to improve the quality of medical care is by education rather than censure or direction from a higher authority. As yet regular audit reviews are uncommon, and whether they will become more widespread remains to be seen. The complaints procedure is outlined.

HOME CARE, AFTER-CARE

See also Abstract Nos. 527, 595, 609

580. ROBERTS, I. **The discharged patient—are we doing our best?** *Nursing Mirror*, Sutton, 1977, Sept. 22, vol. 145, no. 12, pp. 37-39.

After-care studies have shown that only a small proportion of discharged patients who need further care are visited by a district nurse or health visitor. Failure of communication between the hospital and the community services is often at fault, but sometimes the patient's exact needs have not been properly assessed before he leaves hospital. Assessments are usually made in the knowledge of the services available and in terms of various 'groups' of patients. Aftercare needs would be more accurately judged on the basis of the patient's ability to care for himself in his particular domestic circumstances. Adoption of this type of assessment would help in discussing after-care with the patient, his relatives or a community worker.

581. BEIGEL, A. and others. **Practical issues in developing and operating a halfway house program.** *Hospital and Community Psychiatry*, Washington, 1977, Aug., vol. 28, no. 8, pp. 601-607.

The 'halfway house' scheme of the Southern Arizona Mental Health Center has four homes each accommodating 25 people who either need a transitional period after leaving hospital or who can be treated without hospital admission. The average length

of stay is six months. The therapeutic community approach is implemented by the informal, family atmosphere in the house and by the programme of structured activities which include group therapy, vocational training and participation in community volunteer work. There are four full-time therapist counsellors who meet residents individually and help them organize the domestic management of the houses. Help is also provided by consultants and volunteers and the director of the scheme has overall responsibility for policy and liaison with community services. The staff hold frequent meetings to discuss residents' behaviour and plans for their treatment. Residents' feelings about house life are discussed at weekly meetings with counsellors.

SPECIAL DEPARTMENTS

ANAESTHESIA

582. LEIGH, J. M., WALKER, J. and JANAGANATHAN, P. **Effect of preoperative anaesthetic visit on anxiety.** *British Medical Journal*, London, 1977, Oct. 15, vol. 2, pp. 987-989.

The object of this study was to determine whether the pre-operative visit by the anaesthetist was of value in alleviating the patient's anxiety and whether a booklet might be substituted for these visits. Patients undergoing relatively minor surgery were divided into three groups: (i) those who had received a pre-operative visit by a representative of the anaesthetist; (ii) those who had read a booklet; and (iii) those who had done neither. The anxiety levels of all three groups were assessed and found to be significantly lower in patients who had received a visit, but the booklet produced only a very slight fall in anxiety levels. Owing to the increasing work load in the operating theatre, anaesthetists can no longer make pre-operative visits. This study shows that this role can successfully be taken by someone else, possibly the anaesthetic or recovery room nurse, the patient having first read a booklet providing basic information.

PHARMACY

583. HAMMEL, R. J., KING, C. M. and JONES, T. F. **Administrative case study: analysis of a hospital pharmacy's manpower requirements.** *American Journal of Hospital Pharmacy*, Washington, 1977, Sept., vol. 34, no. 9, pp. 969-972.

The development of a method to determine the manpower requirements needed to adequately staff the pharmacy department of the 760-bed University of Michigan Hospitals is described. The Michigan *Hospital Staffing Methodology Manual*, direct observations, interviews and diaries were used to gather data. An example of the data collected for the dispensing area is presented. The data provided a basis for developing productivity standards for current methods and procedures used in the department. In addition, the data facilitated the justification process for allocating existing and requesting future manpower resources.

584. LAUSIER, M. **Computerized hospital information system for an intravenous admixture service.** *American Journal of Hospital Pharmacy*, Washington, 1977, Sept., vol. 34, no. 9, pp. 976-978.

The pharmacy at the 525-bed Maine Medical Center, Portland, operates a centralized unit dose drug distribution system and an intravenous admixture programme for all in-patients. It provides a full service for 24 hours a day, seven days a week, with 40 staff, 14 of whom are pharmacists. This paper describes the application of the hospital-wide medical information system to the intravenous admixture service and compares the computer system with the manual system which preceded it. The computer system will greatly facilitate the expansion of the present intravenous admixture service to include production of small-volume parenterals. In general, the computer distributes medical orders to each user promptly upon physician entry, provides clerical assistance and may be used simultaneously at many locations. Information is printed at all required locations, eliminating hand transcriptions and report distribution. The computer increases the accuracy, completeness, legibility and timeliness of data communication throughout the hospital. In the intravenous admixture service it has improved communications between the nursing stations, allowing more economical use of materials and staff.

585. GRAHAM, J. D. P. and HITCHENS, R. A. N. **The National Poisons Information Service and hospital admissions for children—the experience in Wales of the Cardiff Centre.** *British Medical Journal*, London, 1977, Nov. 19, vol. ii, pp. 1339-1340.

Enquiries to the National Poisons Information Service in Cardiff involving children were compared with admissions to hospital in the eight health authorities in Wales. The areas were ranked according to their usage of the Cardiff NPIC and the number of enquiries declined as the distance from Cardiff increased. The four areas with the highest enquiry rates had the highest admission rates, with the exception of the area in which the Centre is situated. Thus the Centre has a useful but very limited function in reducing hospital admissions and if the service were re-organized on a local level it would be more widely used by general practitioners and others in the community.

586. BENNETT, B. S. and LIPMAN, A. G. **Comparative study of prospective surveillance and voluntary reporting in determining the incidence of adverse drug reactions.** *American Journal of Hospital Pharmacy*, Washington, 1977, Sept., vol. 34, no. 9, pp. 931-936.

In a study of the feasibility of establishing an adverse drug reaction monitoring and reporting programme at the 890-bed Yale-New Haven Hospital, two different systems were compared: a hospital-wide voluntary reporting programme; and a short-term, intensive, prospective surveillance conducted by a pharmacist on a medical and a surgical patient care unit. Data generated by the voluntary system were collected for a 45-day period and data generated by the prospective surveillance system for 21 days. The operation of a monitoring and reporting system for the purpose of maintaining incidence data was not judged to be cost effective. Programmes composed of voluntary reports are poorly complied with, perhaps because physicians and nurses have a low index of suspicion for adverse drug reactions and perceive reporting as a low priority function. Ongoing prospective surveillance programmes are prohibitively labour intensive. Periodic prospective surveillance programmes on representative

patient population samples may be valuable in determining true incidence figures. Periodic publication of new or poorly known adverse drug reactions in an adverse drug reaction bulletin may be a cost-effective means of maintaining an awareness of potential reactions among health professionals.

587. CERTON, J. S. **A uniquely designed pharmacy night cupboard.** *Hospital Pharmacy*, Philadelphia, 1977, Sept., vol. 12, no. 9, pp. 424-426.

In the majority of hospitals, the pharmacy cannot be open 24 hours a day, seven days a week, but even when it is not open drugs are the ultimate responsibility of the pharmacist. One popular method of handling drug orders after pharmacy hours is to stock a night cupboard from which a designated supervisor/co-ordinator takes the required prepackaged drug. The night cupboard at Columbia Health Center, Pittsburgh, is a walk-in room approximately six feet by eight feet containing 815 drugs and 1,430 dosage forms. The walls, each designated by a letter A, B, C or D, are lined with pegboard. The horizontal rows of pegs are numbered consecutively from top to bottom. A card index shows the location of each drug held and the number of packages of the drug held in the bag which is hung on each peg. There is also a refrigerator in the room. The arrangement of the drugs in the room and the procedure for obtaining drugs from the cupboard and replenishment by the pharmacist are described. Two photographs are included.

588. ACHONG, M. R. and others. **Changes in hospital antibiotic therapy after a quality-of-use study.** *Lancet*, London, 1977, Nov. 26, vol. ii, pp. 1118-1122.

The indications for the use and choice of four parenteral antibiotics in a surgical, gynaecological and medical ward of a Canadian hospital were surveyed in 1976. The survey was repeated the following year. In the 1976 survey, treatment was assessed as irrational (that is, unnecessary or inappropriate) in 41.9 per cent, 50 per cent and 12 per cent of patients for the three ward types respectively. Treatment was more rational in 1977, with assessments of 23.6 per cent, 24.6 per cent and 21 per cent. The main changes in therapy were a reduction in the length of prophylactic therapy and a decrease in the number of patients receiving oral antibiotics immediately before or after the parenteral antibiotic, a procedure regarded as irrational in the 1976 survey. The appropriate use of antibiotics, a subject of great importance both to the individual patient and the general population, is discussed.

LABORATORIES

See also Abstract No. 560

589. CARLSON, D. J. **Cost effectiveness of laboratory improvement programs: the viewpoint from the private sector.** *Health Laboratory Science*, Washington, 1977, July, vol. 14, no. 3, pp. 199-205.

The problem of cost-effectiveness of laboratory improvement from the viewpoint of the individual laboratory involves the question of how much expense can be justified for quality control. The costs of quality control have been divided into four categories: prevention costs; appraisal costs; internal failure costs; and compliance costs. Details of these are discussed and the costs of participating in voluntary and mandatory

programmes are compared. Reduction of costs could be achieved by reducing duplication and overlapping of programmes. It is difficult to identify the exact costs in any programme, but it is estimated that for the individual laboratory it may represent 10 to 15 per cent of operating costs.

590. LAMOTTE, L. C. **The impact of laboratory improvement programs on laboratory performance: the CLIA 67 experience.** *Health Laboratory Science*, Washington, 1977, July, vol. 14, no. 3, pp. 213-223.

Under the Clinical Laboratories Improvement Act of 1967, the Center for Disease Control has established specific standards of laboratory performance in each of three areas: staff qualifications, adequacy of internal quality control programmes, and staff competence as demonstrated in performance evaluations. These standards have been detailed in published regulations so that laboratory staff know what is expected of them. This paper reviews the Center's experience in administering the programme. This experience suggests that the key indicators of reliability have been identified and that sensitive measurement of those indicators is now possible and practical. The costs of assuring high quality are inconsequential compared with the costs to the patient and taxpayers of inaccurate test results.

591. JOY, J. W., VAN DUSER, A. L. and INHORN, S. L. **Wisconsin's laboratory evaluation and certification program.** *Health Laboratory Science*, Washington, 1977, July, vol. 14, no. 3, pp. 206-213.

This paper reviews the methods used in the evaluation of test performance and certification in laboratories in Wisconsin, and presents some of the results achieved. The philosophy of the programme has been: (i) to determine and act on the needs of clinical laboratories to upgrade their test performance; (ii) to inform laboratories of the requirements necessary to meet new state and federal regulations; and (iii) to maintain a working relationship to ensure a high degree of quality performance for the public health and safety.

BLOOD TRANSFUSION DEPARTMENT

See Abstract No. 595

DIAGNOSTIC X-RAY DEPARTMENT

592. KREEL, L. and MEIRE, H. B. **The diagnostic process: a comparison of scanning techniques.** *British Medical Journal*, London, 1977, Sept. 24, vol. 2, pp. 809-811.

In choosing between various scanning techniques, the factors to be considered include availability, cost, the expertise of the medical and technical staff and the use to which the equipment is put. Ultrasound, for example, should be used in obstetrics while computerized tomography (CT) has revolutionized neuroradiological diagnosis. It is also incomparable in diagnosis of lung disease and sketetal problems. In many areas there is disagreement over the respective merits of the two systems. These areas include the liver, the pancreas and the pelvis. One technique or the other may be

better suited for a different problem within the same area of the body. There is no substitute for a thorough examination of every patient and good history taking. This procedure should take place before the decision is made about which diagnostic technique to use.

RADIOTHERAPY DEPARTMENT

See Abstract No. 574

PHYSIOTHERAPY DEPARTMENT

593. WARD, A. W. M., DAVISON, C. M. and FRANCIS, B. J. **Physiotherapists who trained at Sheffield and St. Thomas' 1952-1970.** *Health and Social Service Journal*, London, 1977, Nov. 18, vol. 77, no. 4567, pp. F17-F24.

A questionnaire was sent to 1,007 women who qualified as physiotherapists from the training schools at St. Thomas' Hospital, London, and Sheffield between 1952 and 1970. Ninety-four per cent responded, 55 per cent being employed as full or part-time physiotherapists at the time of the survey. Seventy-eight had had a break in employment but had succeeded in returning. The most recently qualified group stayed in practice longer and professional activity dropped to its lowest point eight to 10 years after qualification. Most had a first job near their place of training, but mobility increased with experience. The most common reason for not practising was children, linked with a demand for creches and holiday cover. Other reasons given were the need for a refresher course and a lack of suitable work locally. Respondents felt that physiotherapy gave a high degree of job-satisfaction, but considered that the financial reward in the United Kingdom was poor. The survey showed that 'wastage' affecting the profession need not be total loss, especially where a flexible system allowed for part-time employment.

OCCUPATIONAL THERAPY DEPARTMENT

594. ALASZEWSKI, A. **Occupational therapy—case study of a professional strategy.** *Health and Social Service Journal*, London, 1977, Oct. 14, vol. 87, no. 4562, pp. B5-B8.

Occupational therapists work in the area of medicine known as rehabilitation and direct themselves towards the patient as a whole person. This theme of patient orientation rather than technique is used in relationships between occupational therapists and the other occupational groups, but is a hindrance to the integration of differing therapies. The author discusses how the occupational therapists' strategy impeded the integration of the remedial professions in two particular health districts. In the districts discussed, a new management structure of therapists, following the 1974 reorganization of the health services, did not overcome the predominance of the physiotherapists in the major hospitals. In general, it seems that occupational therapy has developed a firm base in geriatrics in urban areas, and in more rural areas it has developed in small departments attached to small hospitals. The profession could have difficulty in holding its own, especially in the area of acute medicine.

DEPARTMENTS FOR SPECIAL THERAPY

595. COLVIN, B. T. and others. **Regional co-ordinator for haemophilia in domiciliary practice.** *British Medical Journal*, London, 1977, Sept. 24, vol. 2, pp. 814-815.

The North-East Thames Region has appointed a nursing sister to co-ordinate the organization of care for the 412 haemophiliacs in the region. Her initial task was to visit haemophiliac centres to obtain information about patients and the services offered. As a result of the appointment, facilities for home treatment have expanded rapidly. As well as providing supervision for patients on home treatment, the co-ordinator visits schools with haemophiliac pupils and helps to place haemophiliac children in suitable schools. She also maintains the regional register of haemophiliacs and from a central position at the Brentwood blood transfusion centre ensures that supply matches demand for services within the region. A map shows the location of the four main and four associate haemophilia centres.

INTENSIVE CARE UNITS

See also Abstract No. 561

596. LONG, A., PUSHKIN, J. and RUDLIN, M. **Staffing intensive therapy units.** *Nursing Times*, London, 1977, Nov. 24, vol. 73, no. 47, pp. 1836-1838.

To obtain a better understanding of intensive therapy unit staffing an explanatory study was undertaken to find out how staff felt about working in the unit. Two forms of data collection were used: an in-depth interview technique using a tape recorder for collecting the views of the unit nursing officer; and a questionnaire for interviewing the nurses. The study indicated: that there was a high staff turnover, largely because of the desire for further training; and the effect of a low level of staff can be camouflaged because the nurses are prepared to work overtime due to a high degree of job satisfaction. The study draws attention to the need for management to monitor rigorously situations where staffing levels are below establishment and are on the decline.

597. KITCHIN, A. H. and POCOCK, S. J. **Prognosis of patients with acute myocardial infarction admitted to a coronary care unit.** *British Heart Journal*, London, 1977, Nov., vol. 39, no. 11, pp. 1163-1171.

Patients admitted to a coronary care unit during a three-year period (1966 to 1969) were followed-up for periods of up to 7½ years. Of 872 male patients under 70 years of age admitted to the unit, 508 had myocardial infarction. On a basis of history, clinical examination and electrocardiogram, it was possible to identify groups with good and bad prognoses as regards hospital survival. Individual adverse factors were age, previous history of ischaemic heart disease, anterior infarction, persistent sinus tachycardia, pulmonary crepitations, hypotension and raised venous pressure. Multivariate analysis showed four factors remaining significant—age, tachycardia, hypotension and pulmonary crepitations. As a result of treatment of cardiac arrest, hospital mortality, which would otherwise have been 20 per cent, was 17 per cent. In the long-term, individual adverse factors were: previous history of infarction or of hypertension, tachycardia, cardiac arrest, ventricular arrythmia, atrial fibrillation, third heart sound, raised venous pressure and pulmonary crepitations. Multivariate analysis reduced

these to six—previous infarct or hypertension, sinus tachycardia, cardiac arrest, ventricular arrythmia and atrial fibrillation. Of those who survived five years, approximately half had angina. Two-thirds of the under 60 survivors were at their normal work.

598. DELLIPIANI, A. W. and others. **Teeside coronary survey—fatality and comparative severity of patients treated at home, in the hospital ward, and in the coronary care unit after myocardial infarction.** *British Heart Journal*, London, 1977, Nov., vol. 39, no. 11, pp. 1172-1178.

An epidemiological survey of myocardial infarction in Teesside County Borough was completed between April 1972 and April 1973. Cases were notified and divided into those who had suffered a 'definite', 'possible' or 'not' myocardial infarction. Severity factors were measured in the 'definite' cases and the distribution of the various factors studied among home, ward and coronary care treated cases. The results suggest that for those patients admitted to hospital, coronary care units were of benefit, especially if the patient was a woman. There appears, however, to be little evidence that coronary care units benefited the patients who had survived at home for the median interval (three hours) before they came under the care of the general practitioner. The data presented suggest that the cases treated at home were of similar severity to those treated in hospital as assessed by the objective criteria used, even though the reservations which are associated with the exercise are emphasized.

SPECIAL HOSPITALS AND UNITS

OUT-PATIENT

See also Abstract Nos. 603, 605

599. ALENTA, H. P. Las consultas externas. **[Out-patient departments.]** *Policlinica*, Barcelona, 1977, Sept./Oct., no. 41, pp. 37-40, 43-44.

Out-patient consultations in Spain have traditionally been confined to private practice or to charitable institutions, but they may well form the basis for health care in the future. With the help of six diagrams and two tables culled from British and South American sources the author offers practical advice on the planning, organization, and design of a hospital out-patient department. These provide information on the number of consultations expected and the number of specialties required for a given population, the number of patients per session, the accommodation required, and the availability of laboratory and X-ray services.

600. GOLDACRE, M. J. and GATHERER, A. **Peripheral outpatient clinics: use, costs, and benefits.** *British Journal of Preventive and Social Medicine*, London, 1977, Sept., vol. 31, no. 3, pp. 205-208.

A census was taken of out-patient bookings in all hospitals and health centres in Oxfordshire. Nine per cent of all bookings were to 10 peripheral clinics, that is, those outside the main medical centres of Oxford and Banbury. About half of all out-patients were seen at clinics within three or four miles of their homes. The workload

at peripheral clinics was usually local: 75 per cent of patients at these clinics lived either in or near the town in which the clinic was held. Patients from further away tended to travel to central clinics. Higher than average booking rates for each town were, in general, associated only with specialities which held a clinic in the town. Peripheral clinics were associated with a lower work load than central clinics, but a higher overall load from the town where they were sited. Peripheral clinics saved patients a total of 35,797 miles of travelling. The following need to be considered when deciding whether to establish a peripheral clinic: (i) the existing clinic facilities; (ii) the views of local doctors and patients; and (iii) the various costs and benefits of such clinics.

CASUALTY AND ACCIDENT

See also Abstract Nos. 489, 610, 631

601. HOUTCHENS, B. A. **Major trauma in the rural mountain west.** *Journal of the American College of Emergency Physicians*, Lansing, 1977, Aug., vol. 6, no. 8, pp. 343-350.

A disproportionately high percentage of trauma fatalities occur in rural areas, and almost half of these fatalities occur after arrival at a community hospital. A review of the initial evaluation and management of major trauma victims in 20 small rural community hospitals in Utah, Nevada and Wyoming revealed a surprisingly high incidence of departure from well-defined standards. Reducing the magnitude of this rural hospital component of trauma facilities will require application of the same standards of initial evaluation and management which have proved effective in major medical centre emergency departments.

602. ROBERTS, J., FARRER, J. and HARVEY, P. **A progressive study of the emergency room demand by the community.** *Medical Informatics*, London, 1977, Sept., vol. 2, no. 3, pp. 197-201.

This paper reports the benefits which can be derived by medical and administrative staff of a district general hospital using a computer system to analyse the information held in the records of the casualty department. The system has been developed at the Royal Lancaster Infirmary, with the assistance of the University of Lancaster Computer Services Department. Details are given of the modifications made to the system in the light of continuing research which has now extended over eight years and is still in progress. Casualty attendance profiles have provided detailed, statistically acceptable data for a number of studies of the health and welfare services offered in the town. Although no two hospitals deal with the same cross-sections of the public, the general trends demonstrated here are of more than local interest. It has been demonstrated that the population attending the department changes over the years and that the service provided needs to be modified too.

603. GIANNUZZO, E. Sull'organizzazione dei dipartimenti di emergenza e di accettazione nella regione Piemonte. **[On the organization of emergency and reception departments in the Piedmont region.]** *Ospedale*, Torino, 1977, June/July, vol. 30, nos. 6/7, pp. 154-158.

In 1975 the regional government in Piedmont decided that emergency services

would be provided in the region by 19 first-level emergency departments and by four second-level departments. The latter were to be autonomous and provide a round-the-clock service, with a staff of approximately 80 doctors; the first-level departments, on the other hand, were to depend on the staff of other departments in their hospitals. The author believes that this approach is anachronistic and proposes a model wherein each first-level emergency department is autonomous and has its own resuscitation centre, coronary unit, obstetrics and gynaecology unit, and paediatric unit, each with a doctor on duty round the clock. The total medical staff allocation would be between 12 and 16, and specialist services would be provided by other departments in the hospital.

DAY HOSPITALS

604. PEACH, H. and PATHY, M. S. **Evaluation of patients' assessment of day hospital care.** *British Journal of Preventive and Social Medicine*, London, 1977, Sept., vol. 31, no. 3, pp. 209-210.

For this study, 15 questionnaires were put to 51 patients attending a geriatric day hospital. All patients received medical and nursing care, and with 14 patients there was an element of social care. Men tended to find the medical care more beneficial, while the occupational therapy appealed more to the women, but the high scores given by all the patients suggested that they found the day hospital a satisfactory form of care.

605. RENNIE, P. H. **Is ambulatory care worth it?** *Hospital Administration in Canada*, Don Mills, 1977, Oct., vol. 19, no. 10, pp. 25-28.

Ambulatory care has been encouraged in Canada as an answer to economic stringencies in hospitals, but because hospitals are financed according to the number of beds and patient days, funds are lacking for day care services. Day surgery, for example, must be viewed as a substitute for in-patient facilities and not as an extra service. The statistical and financial effect of a day surgery scheme on the Greater Niagara and the Kitchener Waterloo General Hospitals, Ontario, is studied in detail. The study shows that day surgery can only be financially beneficial to a hospital if bed allocations are suitably adjusted.

CHEST

See also Abstract No. 563

606. PARIENTE, R. and BALDEYROU, P. Méthodes d'étude des besoins hospitaliers en pneumologie. **[Methods of studying hospital needs in dealing with respiratory disorders.]** *Hôpital à Paris*, Paris, 1977, Sept./Oct., no. 41, pp. 405-413.

The authors divided patients needing treatment for respiratory diseases into six groups in which technological requirements and length of stay in hospital were similar, and from the prevalence and incidence of the diseases in each group attempted to assess present hospital requirements. In order to estimate requirements for 1985 they studied population trends in the Paris area and tried to predict the rise or fall in the numbers in each group per 100,000 population, as well as possible variations in

technological advances. The groups studied were: chronic respiratory insufficiency, cancer of the thorax, tuberculosis, infections of the respiratory apparatus, vascular diseases of the lung, and miscellaneous. They concluded that the Paris area requires 2,200 beds for these patients at present and suggest that out-patient facilities and programmes of prevention and screening should be expanded.

CHILDREN

See also Abstract Nos. 573, 585

607. WYNNE, J. and HULL, D. **Why are children admitted to hospital?** *British Medical Journal*, London, 1977, Oct. 29, vol. ii, pp. 1140-1142.

The records of 399 consecutive, non-planned acute medical admissions to the Nottingham Children's Hospital were examined from October 1975 to January 1976. In each case, medical and social histories were taken and a note was made of the source of referral. Over 61 per cent of the children were referred directly to the casualty department by their parents. Twenty-two per cent referred in this way and nine per cent of the rest were admitted primarily because of problems and limitations in the home. The disease factor was the excuse rather than the reason for admission and in some areas as many as one in four of the children were admitted under one year of age. The hospital and supporting services should be aware of the needs of the parents as well as those of the sick children in their catchment area.

608. **A child life program in action.** *Canadian Nurse*, Montreal, 1977, Nov., vol. 73, no. 11, pp. 42-43.

The child life programmes at the Children's Hospital of Eastern Ontario began three years ago when the hospital opened. A total of nine child life staff and more than 150 volunteers are now involved in the various programmes. The aim of the programmes is to minimize the traumatic effects of illness and hospital care and to encourage the continued growth of the child or adolescent—physically, emotionally, intellectually and socially. The child life staff also aim to foster the involvement in children's activities of all who are in contact with the child and his family. The programmes provided, of which brief details are given, include: infant, pre-school, school age, education, youth unit, clinical investigation and dialysis unit, intensive care unit, evening, kitchen, children's library, outdoor facilities, special entertainment, week-end, in-service education and practicum placements, orientation, out-patients and special projects.

609. JOLLY, J. D. **Child care in North America-1. Round-the-clock home care.** *Nursing Times*, London, 1977, Nov. 24, vol. 73, no. 47, pp. 1843-1844.

The home care unit, Montreal Children's Hospital, provides a 24-hour, seven-day-a-week service, with a staff of a consultant paediatrician, houseman, three nurse practitioners, physiotherapist and social worker. Part-time consultation is available from a dietitian, occupational therapist and psychiatrist. Currently about 125 children are being attended at any one time. To provide the 24-hour cover, each nurse practitioner carries the 'protocol card' of every child when she is on call; duplicates are kept

in the accident and emergency department. Brief details are given of the type of care provided and the procedures followed.

610. REECE, R. and HATTEM, P. **The hospital child abuse team: an institutional response to an epidemic.** *Health Care Management Review*, Germantown, 1977, vol. 2, no. 3, pp. 31-35.

Cases of child abuse are appearing more frequently in emergency departments. The staff of these departments are recognizing them more readily, but are poorly prepared to deal with them alone. The child abuse team is one model of institutional shared competency with responsibility for this medical, social and legal dilemma. Composition of the team may vary, but the irreducible minimum seems to be social workers, nurses and physicians, together with consultants such as lawyers, psychiatrists/psychologists, play therapists and public agency representatives. At Boston (Mass.) City Hospital members of the child abuse team are available from 0900 to 1700 five days a week. The procedure followed is outlined. Some recommendations are made for preventing child abuse.

611. BIRMINGHAM, V. H., ROGERS, M. B. and SCHMIDT, P. J. **Implementing a parent involvement program in a state hospital and school for children.** *Children Today*, Washington, 1977, July/Aug., vol. 6, no. 4, pp. 20-23.

The Gaebler Children's Unit Hospital and School of Metropolitan State Hospital, Waltham, Mass., provides both in-patient and day care psychiatric services for children between the ages of six and 16. A parent involvement programme was devised to help parents see the unit as a group of caring people who could help them with their problems. Conversely, the unit hoped to become more responsive to parents' needs. At first, parents tended only to want to talk to each other, but gradually they accepted the support of a social worker or doctor in discussions of their children's treatment or schooling. Different structured discussion groups were formed to deal with various topics and family activity groups were formed to cater for the needs of all the family members and not just the child receiving treatment. Other groups for parents centre on various tasks and skills. The programme co-ordinator acts as an intermediary between the family and the unit and explains the programme to other members of staff, of whom a large majority support the programme's activities.

612. RIEGER, N. I. and DEVRIES, A. G. **A model training program for child mental health specialists.** *Hospital and Community Psychiatry*, Washington, 1977, Sept., vol. 28, no. 9, pp. 690-693.

The Child Mental Health Specialist Training Program, established in 1970 at the Camarillo State Hospital, California, emphasizes learning in a clinical rather than an academic setting. The course, at any of three levels, lasts two years. Clinical experience of 20 hours per week is supplemented by eight to 12 hours in classes taught by the staff of the Camarillo Children's Treatment Center. All trainees are expected to acquire skills in dealing with the normal, as well as the disturbed child. So far, one third of all the applicants have been accepted for the course and less than five per cent have dropped out. Because of rapid changes in treatment, the Camarillo Scheme aims to equip students with skills which are versatile and flexible and almost all have found employment shortly after completing the course. Employers rate the job performance of Camarillo students very highly.

GERIATRICS AND LONG-STAY

See also Abstract Nos. 496, 553, 604, 630

613. BJÖRCK, S. Gruppvård i Fellingsbro: Personalen nöjd-vill inte byta tillbaka. **[Group care in Fellingsbro nursing home: the staff are happy and will not go back to the old system.]** *Vårdfacket*, Stockholm, 1977, Aug. 25, no. 15, pp. 18-21.

In 1974 the male nurse in charge of Fellingsbro 'nursing' (i.e. old people's) home commenced preparations for the introduction of group care, which started in January 1976. Information was collected from the Nursing Association, the Hospitals Rationalisation Institute, and from a staff study tour to Denmark. Group care originally operated during office hours only, five days a week, but since April 1977 it has been extended to cover the hours from 0700 to 2000, seven days a week. The 34 patients are divided into two equal groups, with a nurse responsible for the care of each and a sister in overall charge. Contact with the patients has been improved and extended, as it has with other staff categories. Each group holds a daily conference in which an administrative officer, the occupational therapist and physiotherapist also take part when available. There is a nursing plan for each patient in the home, based on common decisions made in conference. Group care makes great demands on the sister—she must be very active, and yet ensure that she does not do *all* the work. The entire group discusses medication, possible side-effects, etc., and makes group decisions about administration. Staff turnover and sickness absenteeism have dropped significantly, and the home has become very popular amongst older citizens in the County. The County is now drawing on the staff's experience for instructing staff at other long-stay nursing homes.

NEUROLOGY AND NEUROSURGERY

614. SOHLBERG, L. Neurologavdelning i Ume å prövar gruppvård—personalen positiv: hoppas fler får chansen pröva på det här. **[Staff approve of group care experiment in the Umeå Central Hospital neurology unit: hopefully there will be more opportunities to try the experiment out.]** *Vårdfacket*, Stockholm, 1977, Aug. 11, no. 14, pp. 22-24.

Group care was introduced on an experimental basis in the Neurological Unit of Umeå Central Hospital in September 1976, after a period of preparation beginning in early 1974. At this time re-organization was seen to be necessary when the unit appointed a new consultant, who radically increased patient turnover (and thus the work load) in a ward with an establishment based on long-stay care. The ward sister and matron visited Rigs-hospitalet in Copenhagen, where a ward has practised group care since 1969, and returned with a very good impression of the effect on both patients and staff. After a series of staff meetings, the experiment was agreed to by the county, and three more nurses were sent on a study tour to Denmark. An extra nurse started on the ward at the commencement of the experiment, a temporary post being made permanent. The ward has divided its patients into two groups of 15, each group being the responsibility of a team consisting of two staff nurses, one nurse, four auxiliaries, part of the time of a physiotherapist and a doctor. The ward sister is in overall charge of both teams. The system operates from 0700 to 1600, five days a week, there always being at least three staff available to a group. Medical staff, who are not used to meeting group care, value the high level of engagement and knowledge in the teams. Staff

have improved contact with patients and are able to provide them with more information, and patients are happy not to have to get to know so many new faces. Group care is a way of improving the efficiency of nursing on acute (short-stay) wards. The article is illustrated with two interior photographs from the ward concerned.

EAR, NOSE AND THROAT

615. HOLM, T. Programorientert budsjett- og regnskapssystem. **[The programme orientated budgetary and accounting system and its possible use in the health sector.]** *Norsk Sykehustidende*, Oslo, 1977, Aug., vol. 50, no. 8, pp. 147-153.

The health of the population depends not only on the money spent on the health service but also on decisions made on housing, schools, town planning, engineering, etc. Programme-orientated budgetary and accounting systems aim to make it possible to obtain meaningful answers to questions concerning the combination of possible actions in the public sector which will provide the optimum solution to a certain community problem within the given economic framework or the resources which must be used (budgetary) or have been used (accounting) to attain certain communal ends. The Norwegian Institute for Hospital Research has carried out a trial project involving otorhinolaryngological (ENT) care in South Trondhjem. The aim of the project was to prepare an overall plan for the ENT specialty in the county—i.e. an apparatus applicable in the establishment of a budget. The proposals involved a programme classification (fig. 1, p. 149); an encoded programme orientated budget and accounts scheme (Table 1, pp. 149, 150) comprising plan figures for each part of the programme (example shown in Table 2, p. 150); and draft proposals for a Programme Note. A figure illustrates the chain of command from county council to health, schools and factory inspectorate authorities and back, and the article closes with a detailed estimate of the cost of each portion of the plan (fig. 4). There are frequent references to the Institute's report (NIS-rapport 2/77: *Programorientert budsjett- og regnskapssystem.* (STF81 A77002). Trondheim, 1977).

616. ROSS, T. **Deaf unit, Whittingham Hospital.** *Nursing Mirror*, Sutton, 1977, Nov. 24, vol. 145, no. 21, pp. 20-22.

The Deaf Unit at Whittingham Hospital, near Preston, Lancs., is the only centre of its kind for psychiatric patients who are also deaf. The unit accommodates 26 adults and adolescents and all the staff learn to communicate in sign language. The nurses do not find the work any more demanding than in a general psychiatric hospital and all the patients benefit from their stay in the unit. Observation and communication to assess mental handicap are favoured rather than formal tests which are unreliable in the deaf patients. Many deaf people find lip-reading difficult to learn, and in the unit the emphasis is upon sign language, combined with lip-reading, the written word and gestures to provide a 'total communication'.

CARDIOLOGY

See Abstract Nos. 537, 546, 597, 598

ORTHOPAEDICS

617. TREMLETT, G. **Patient satisfaction in an orthopaedic ward.** *Nursing Times*, London, 1977, Nov. 17, vol. 73, no. 46, pp. 1801-1804.

A survey to ascertain patients' satisfaction and their knowledge of communication procedures in hospital was carried out in one unit of an orthopaedic hospital. In general, the social and psychological aspects of treatment were praised and only five of the 20 patients interviewed were other than satisfied with their hospital stay. Those who had been in hospital for four to 13 days were more critical than longer stay patients, but less critical than those who had never been in hospital before. Only one patient out of 14 who had been given an information booklet about the hospital understood from it how to make a complaint. Knowledge of the complaints procedure bore no relation to the small number of patients who made a complaint to the nursing staff. It would appear that the attitude of the staff and the general atmosphere of the hospital may be more influential in creating confidence in the patient than any official complaints procedure.

UROLOGY

618. KIESSWETTER, H. Rationalisierung von Diagnostik und Therapie in der Urologie durch Computereinsatz. **[Rationalization of diagnosis and therapy in urology through the use of computers.]** *Mitteilungen der Österreichischen Sanitätsverwaltung*, Vienna, 1977, Oct., vol. 78, no. 10, pp. 264-266.

A computerized documentation system, similar to the Professional Activity Study in the United States, has been in use since 1972 to monitor performance in six urology departments of hospitals in Vienna. The statistics thrown up, and their significance for possible rationalization of the diagnosis and treatment of urological conditions, are described with particular reference to standard prostate operations. This shows that pre-operative stay in hospital varies from seven days to 14.6 days in the six hospitals (this compares with two to four days in United States hospitals). If this period were reduced to seven days in all the Vienna hospitals there would be a saving of 7,628 patient days in three years. The factors affecting length of pre-operative stay are assessed.

619. GRELOT, J.-P. and SOUFFLET, H. Évaluation du coût d'une politique de traitement de l'insuffisance rénale chronique. **[Cost analysis in the treatment of acute renal failure.]** *Hôpital à Paris*, Paris, 1977, Sept./Oct., no. 41, pp. 421-428.

A sample of 60 patients who received renal transplants was compared with another group treated by dialysis as to cost of treatment and life expectancy. The authors estimated the costs of transplantation and of a dialysis session, the annual costs engendered by 100 new patients by type of treatment and per annum, and the costs of treating the 2,500 cases per annum envisaged in the French Government's VIIth Plan policy directives. Although transplantation was found to be cheaper than dialysis and the expectation of life of the transplant patients higher, it is pointed out that not all patients can be given transplants either for medical reasons or because the number of kidneys available is insufficient. Also all transplant patients require dialysis while awaiting a graft, and some 20 per cent of transplant patients do not survive the first year. The article includes four graphs and four tables.

SURGERY

See Abstract Nos. 572, 582

MATERNITY

See also Abstract No. 564

620. WALKER, J. F. **Improving maternity care by midwifery research.** *Nursing Times*, London, 1977, Sept. 22, vol. 73, no. 38, pp. 1489-1491.

Great advances have been made in the application of scientific methods to the physiological aspects of childbirth, and the social and psychological aspects are now attracting more attention. The midwife has a great opportunity to apply new knowledge in her practice and more midwives are becoming involved in developing research. A systematic approach to planning midwifery care, including assessment and evaluation, should provide problems for research and show where further study is needed. During the planning process, gaps in knowledge and lack of preparation amongst prospective parents will be apparent, and areas where change and improvement are needed will come to light.

621. ALBERMAN, E. and others. **Arrangements for special and intensive care of the newborn.** *British Medical Journal*, London, 1977, Oct. 22, vol. ii, pp. 1045-1047.

All 62 special care baby units in three of the Thames health regions completed a one-day census on the number of infants, staffing, equipment and facilities. The results were assessed in the light of recommendations made by the Expert Group on Special Care for Babies, set up by the Department of Health and Social Security. Although the provision of cots was higher than suggested and the occupancy rate was lower, some units did not have a resident paediatrician and some had an inadequate number of trained nurses on night duty. Some units lacked essential equipment, while some small units had expensive equipment which was probably underused. Evidence of: (i) a decrease in the number of babies needing special care; and (ii) an uneven distribution of staff and equipment, indicate a need for further rationalising the provision of special care units. Factors to be considered in planning include: (i) the size of the child-bearing population; (ii) the percentage of infants of low birth weights; (iii) the proximity of specialized facilities; and (iv) the effectiveness of care provided in existing special care units.

PSYCHIATRY

See also Abstract Nos. 475, 515, 523, 524, 573, 581, 611, 616

622. BACHRACH, L. L. **Deinstitutionalization of mental health services in rural areas.** *Hospital and Community Psychiatry*, Washington, 1977, Sept., vol. 28, no. 9, pp. 669-672.

Avoidance of institutional care involves the expansion of community-based services for the mentally ill. Problems arising from a shortage of such services tend to be more apparent in rural areas owing to: (i) the fluctuating population; (ii) a shortage of

suitable staff; and (iii) lack of funds. Patients often have to be transferred to urban areas for after-care, resulting in further psychological and social problems. Rural patients and rural psychiatric staff are often affected by a lack of anonymity and a resistance to change. However, the rural sense of community can help in the provision of grass-roots care and the physician may have access to helpful information about his patient which would be difficult to obtain in an urban setting.

623. ECKMANN, F. and IMMICH, H. Zur Verweildauer in psychiatrischen Krankenhäusern. **[Length of stay in psychiatric hospitals.]** *Fortschritte der Medizin*, München, 1977, Nov. 17, vol. 95, no. 43, pp. 2581-2582, 2618.

A study of the medical records at the three State psychiatric hospitals in Schleswig-Holstein, the results of which are set out in detailed statistical tables, shows that there is no correlation between length of stay on the one hand and whether the patient comes from town or country, or whether his home is near or far from the hospital on the other. The only certain and constant relationship is between length of stay and diagnosis.

624. PHILLIPS, M. and others. **Continuous observation—Part I. Who needs it?** *Canadian Psychiatric Association Journal*, Ottawa, 1977, Feb., vol. 22, no. 1, pp. 25-27.

The objectives of this study, which was carried out at the Clark Institute of Psychiatry, Toronto, were to identify: (i) the type of patient needing continuous observation; (ii) the reasons why it was prescribed; and (iii) to evaluate its therapeutic value to the patient. Data was obtained by a 10-year retrospective study of nursing records of patients with a history of admission for continuous observation and an attitude questionnaire to all nursing staff. The study found that the typical patient was likely to be a Canadian female with a history of admission for continuous observation with schizophrenia or depression, aged 30-50 if a depressive and 15-20 or 35-40 if schizophrenic.

625. PHILLIPS, M. and others. **Continuous observation—Part II. Absenteeism amongst nursing staff as a response to the extra workload.** *Canadian Psychiatric Association Journal*, Ottawa, 1977, Feb., vol. 22, no. 1, pp. 29-30.

This article describes an extension of a recent study on attitudes to continuous observation carried out at the Clark Institute of Psychiatry, Toronto and investigates the strain on nursing workload produced by continuous observation. The methodology employed an analysis of sickness absence in conjunction with continuous observation over a two-year period using nursing and staff records. It was found that there was a statistically significant correlation between hours of continuous observation and sickness absence implying that this therapy imposed additional stress on nursing workload.

626. GRIVOUS, H. and SONNIER, A. Hôpitaux généraux et politique de secteur en psychiatrie. **[General hospitals and a move towards 'sectorization' in psychiatry.]** *Techniques Hospitalières*, Le Kremlin-Bicêtre, 1977, Oct., vol. 33, no. 385, pp. 66-75.

The authors examine the relationship between psychiatric units in general hospitals in Paris and the psychiatric sector policy, whereby the country is divided into a number

of sectors, each containing approximately 70,000 inhabitants, and the psychiatric patients in each sector are treated by one and the same medico-social team throughout their illness. From a statistical analysis presented in the form of four tables and from their own experience at the Hôtel-Dieu they draw the conclusion that sectorization is too inflexible for a city of the size of Paris where the population is constantly on the move.

627. Welterhof in Heerlen; een goed voorbeeld: management ten behoeve van het zelf-doen. **[The Welterhof Psychiatric Centre, Heerlen: a good example of management with a view to encouraging patient self-reliance.]** *Instelling-Management*, Amsterdam, 1977, Oct. 26, vol. 9, no. 10, pp. 10-12, 14.

The 399-bed Welterhof Psychiatric Centre accommodates all age groups and is laid out as a village with a block of flats (236 beds), a hospital (24 beds), emergency unit, polyclinic, day centre, buildings for sport, creative and occupational therapy, restaurant, kitchen, technical buildings and connecting streets with shops, post-office, library, etc. On the principle of self-reliance in therapeutic treatment, patients are organized into groups of 12 and daily receive a certain sum (Fl. 2.60 in 1976) per patient. Patients then plan their own activities within and together with their group and are responsible for buying their own snack meals and paying for their hairdressing, laundering, postage stamps, etc. Financial arrangements between the Centre, insurance companies and specialists are not yet satisfactorily solved. The Centre's organization is hierarchical with a chief official responsible for general management, an operational section which delegates tasks and a functional section concerned with directives and advice on technical matters. The paper includes details of bed-occupation, a map of the catchment area (300,000 inhabitants), a plan of the complex, some financial details, a diagram of the organizational scheme and three pictures.

628. SOUTH EAST THAMES REGIONAL HEALTH AUTHORITY. **Development and the management of mental illness and mental handicap services: report of a seminar, April 26-28, 1976, held at Southborough, Tunbridge Wells, reported by Christine Bowler, Croydon, S.E. Thames RHA,** [1977] [v], 40pp.

The South East Thames Regional Health Authority considers that the philosophies embodied in the Government White Papers 'Better Services for the Mentally Handicapped' and 'Better Services for the Mentally Ill' should be used as frameworks within which to develop the services for the mentally ill and mentally handicapped in the region. The success of such development programmes depends upon commitment by management and staff at all levels. A seminar was held for 97 senior representatives to formulate the regional strategies, analyse the problems of the present management system and the possible solutions.

629. SOUTH EAST THAMES REGIONAL HEALTH AUTHORITY. **The further development of the management of services for the mentally ill and the mentally handicapped: report of a seminar, October 12-13, 1976, held at Southborough, Tunbridge Wells, Croydon, S.E. Thames RHA,** [1977], 31pp.

This seminar was a follow-up to one held in April, 1976, by the South East Thames Regional Health Authority, when staff were asked to identify problems and set action programmes in order to meet the recommendations of the Government's White

Papers 'Better Services for the Mentally Ill' and 'Better Services for the Mentally Handicapped'. The aim of the present seminar was to obtain feedback on the action initiated or taken during the last six months and to stimulate the sharing of ideas.

630. BRETON, S. and COCKRAM, M. E. A. **A simple programme designed to counteract some of the effects of institutionalization in longterm psychiatric wards.** *Journal of Advanced Nursing*, London, 1977, Sept., vol. 2, no. 5, pp. 495-501.

Long-stay, geriatric female patients in Parc Hospital, Bridgend, took part in a scheme to improve spontaneity and increase initiative. A 'nucleus' of six to eight more sociable patients chatted to members of staff for half an hour two afternoons a week. Extra activities were also provided for the ward as a whole. Patients' progress was assessed from their contributions to both the group discussions and the more general activities. Results showed a general trend towards patients doing something on their own initiative, with a slightly more marked improvement among the 'nucleus' group. The scheme was adapted for use on other wards; for example, where patients were more regressed, more frequent but shorter group meetings of only four patients were more suitable. The data collected were not suited to statistical analysis, but if gathered more consistently, could provide a basis for further research.

631. SOREFF, S. M. and ELKINS, A. M. **A community mental health center's consultation service in a general hospital.** *Hospital and Community Psychiatry*, Washington, 1977, Oct., vol. 28, no. 10, pp. 749-752.

When the 550-bed Maine Medical Center's division of psychiatry became the department of psychiatry, a community mental health centre was established within the department. The centre operates a psychiatric consultation programme as an integral part of the hospital's medical emergency service. A major advantage of the system is that it allows the hospital to provide immediate comprehensive services—psychiatric as well as medical—to emergency patients. The consultation programme also accepts referrals of medical patients admitted with apparent emotional problems and of patients from such sources outside the hospital as paediatricians, clergymen and other community agencies.

632. HARDY, C. J. **A record system for mental handicap.** *Medical Record and Health Care Information Journal*, Truro, 1977, Nov., vol. 18, no. 4, pp. 318-327.

This paper describes an attempt to use information management techniques to create a case record for the long-term care of the mentally handicapped. The project was initiated and supported by the State of Hawaii Department of Health. There are six elements in the record: (i) a succinct but highly descriptive profile of the patient; (ii) a programmes list, defining the programmes in which the patient is currently engaged; (iii) plans and approaches, where each programme is tailored to the resident; (iv) programme monitors, where each programme is charted symbolically; (v) a provision for free-text entries, called interdisciplinary entries; and (vi) a divided record separated physically into active and inactive components. By planning the care process around the data retrieval function, by structuring tightly the documentation process, and by taking many steps to eliminate irrelevant or meaningless entries, it has been possible to record much of the data with symbols rather than text. The system, after two years' experience, appears to provide improvement in clarity and accessibility of

data, a reduction in volume and, above all, a record which is dynamically involved in the delivery of care. Drawbacks include the difficulty of changing long-standing record-keeping habits, and the difficulties experienced by occasional outsiders who must work with the records.

633. SYLVESTER, P. E. **Adventure play for the handicapped.** *Nursing Times*, London, 1977, Nov. 3, vol. 73, no. 44, pp. 1702-1704.

With £20,000 raised by the hospital's League of Friends and the labour of many volunteers, an area of land, which included a derelict cottage and two adjoining barns, at St. Lawrence's Hospital, Caterham, has provided a restored cottage, a heated indoor playground, a soft playroom, an outdoor playground with a large sand-pit and paddling pool, and a camping site. The playground is used daily throughout the year, the numbers varying from 50 to 200, many of whom are adults. Parents, groups from centres and hostels outside the hospital and children from the staff holiday club also use the playground and mingle freely with the residents. The Area Health Authority created one playleader post in the first year and a second in the following year. The philosophy of adventure play for the mentally handicapped is outlined. Six photographs of the playground are included.

634. FOWLER, D. R. and MAYFIELD, D. G. **Psychiatric hospitalization I. Comparison of public and private delivery systems.** *Diseases of the Nervous System*, Memphis, 1977, May, vol. 38, no. 5, pp. 314-317.

The effect of financial requirements for admission on the delivery of psychiatric treatment services was studied by comparing all patients admitted to the psychiatric services of a public and a private general hospital, serving geographically similar areas. Patients admitted to these two services (staffed by the same Department of Psychiatry) were compared using a variety of factors. The two groups differed in a wide number of factors including presenting problems, diagnoses and psychological concept of their illnesses. The public hospital patients were less likely to receive somatic treatments and more likely to have a longer stay in hospital. The findings suggest that financial requirements for admission affect the intensity and expeditiousness of the treatment.

635. MAYFIELD, D. G. and FOWLER, D. R. **Psychiatric hospitalization II. Effect of social class and delivery systems.** *Diseases of the Nervous System*, Memphis, 1977, May, vol. 38, no. 5, pp. 320-323.

The effects of social class and delivery systems on admission and behavioural variables, diagnosis, treatment and length of stay in hospital were studied by comparing patients admitted over a one-year period to the psychiatric services of a public and private general hospital, staffed by the same Department of Psychiatry. Patients were of similar age and sex and matched by social class. Patients diagnosed as schizophrenic were more common in the upper classes at the private facility and the lower classes at the public facility. Somatic treatments and length of stay also varied according to social class as well as delivery system. The results imply that economic differences between public and private delivery systems operate to select patients for admission and affect treatment, perhaps to the detriment of patients in both systems.

636. HOLLOWAY, C. **Systems performance: human factors and systems failures.** Units 13/14. Mental health service (TD342 13/14) Milton Keynes, Open University Press, 1976, 162pp. £2.40

The aims of the Open University Course on Mental Health Service Provision are presented. Aspects covered by the course include: an overview of the history of mental health care; a case study—the Payne report; social structure; processes in the management of mental illness; resources; planning and evaluation; root definitions and conceptualizations of a mental health service; and the existing, the ideal and the practicable. A list of references is included together with answers to the self assessment questions.

637. NATIONAL ASSOCIATION FOR MENTAL HEALTH. **Mind action for students: a handbook for students and those interested in student voluntary activities in mental health, based on the work of Tim Gauntlett, student liaison officer for Mind 1972-1976.** London, National Association for Mental Health, 1977, [ii], 28pp. £1.25

This handbook is designed as a source of basic information and a practical guide for students who want to know more and talk more about mental health. Aspects considered include: why students should care about mental health; MIND Action for students; what can students do; the organization of student activities; how to operate efficiently; and models of organization. Five appendices are included covering; additional information; organization of health and social services; list of workshops and reports; selected reading list and MIND Publications List: and groups and organizations concerned with mental illness, mental handicap and related problems.

638. GINSBERG, G. and MARKS, I. **Costs and benefits of behavioural psychotherapy: a pilot study of neurotics treated by nurse-therapists.** *Psychological Medicine*, London, 1977, Nov., vol. 7, no. 4, pp. 685-700.

From 1972 to 1974, five nurse therapists were trained in the Bethlem/Maudsley Hospital. This paper analyses the costs and benefits of their treatment of 42 neurotic patients during their secondment to four other psychiatric hospitals and a group of general practitioners. The mean period of treatment was nine sessions (16 hours). The year before and after treatment was studied. Apart from a significant and lasting reduction in patients' distress, economic benefits to them, their families and the community yielded a worthwhile internal rate of return when benefits from the cohort continue for three years, a reasonable assumption on other available evidence. Though untreated phobias did not improve elsewhere over a follow-up of five years, a controlled study would seem desirable.

639. GERSHON, M. and BILLER, H. B. **The other helpers: paraprofessionals and nonprofessionals in mental health.** Lexington, Mass., Lexington Books, 1977, xi, 270pp. £11.90

The aim of this book is to provide a guide to the non-professional mental health literature. The three basic goals are: (i) to critically examine selected training schemes in the literature on non-professionals; (ii) to provide a source book for readers interested in the many aspects of this field; and (iii) to suggest a model for conceptualizing, implementing and evaluating non-professional training schemes. Aspects considered

include: the non-professional revolution; goals and organization; the paraprofessionals; community agents; the medical and allied health professionals; urban agents; self-help schemes; the indigenous poor and 'exotic' helpers; parents as mental health helpers; mental health volunteers; and the implications of training schemes for mental health professionals. A bibliography of the literature and author and subject indexes are included.

640. SZASZ, T. **Psychiatric slavery.** London, Collier MacMillan, 1977, xv, 159pp. £6.75

This book is an analysis of the issues arising from the compulsory admission of Kenneth Donaldson to Florida State Hospital. The problems of psychiatry and law in the United States are discussed. Aspects covered include: the court case and legal briefs; the Supreme Court's decision; interpretation of the Supreme Court's decision; the right to treatment and the right to treat; and a definition of chattel slavery and psychiatric slavery.

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